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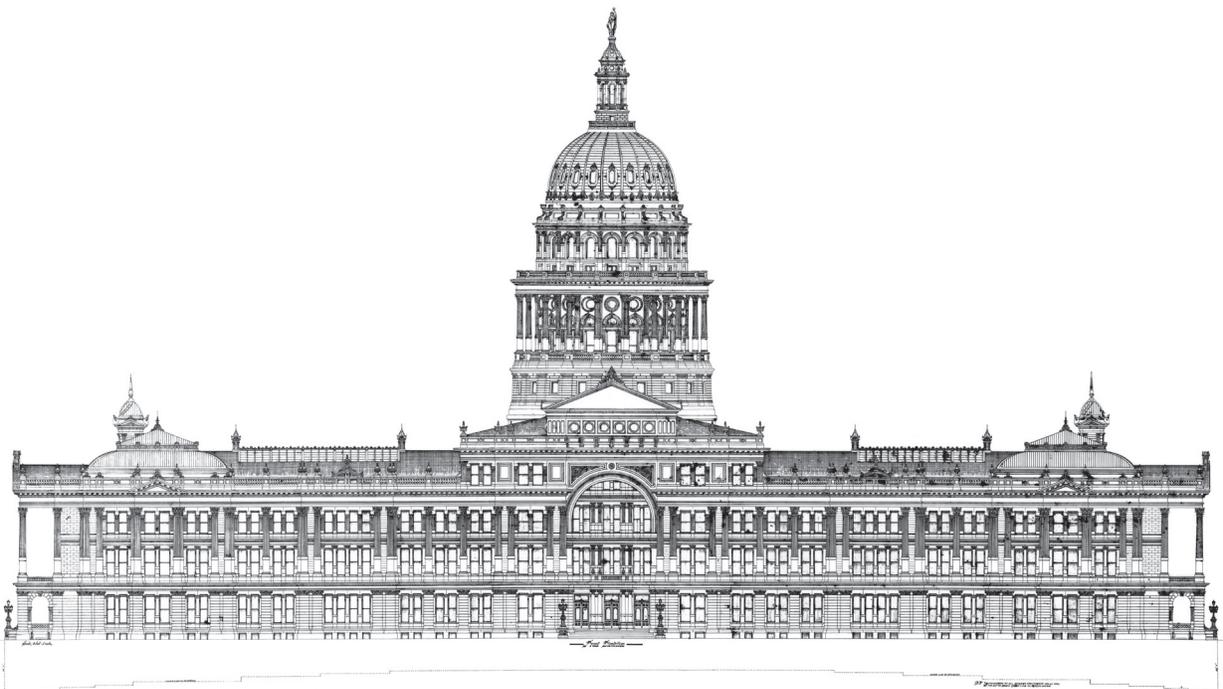
# INTERIM REPORT

TO THE

## 82ND TEXAS LEGISLATURE

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*House Committee on*  
HUMAN SERVICES  
December 2010



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**HOUSE COMMITTEE ON HUMAN SERVICES  
TEXAS HOUSE OF REPRESENTATIVES  
INTERIM REPORT 2010**

**A REPORT TO THE  
HOUSE OF REPRESENTATIVES  
82ND TEXAS LEGISLATURE**

**PATRICK ROSE  
CHAIRMAN**

**COMMITTEE CLERK  
MICHAEL RUGGIERI**

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Committee On  
Human Services

December 21, 2010

Patrick Rose  
Chairman

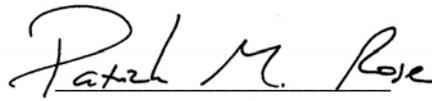
P.O. Box 2910  
Austin, Texas 78768-2910

The Honorable Joe Straus  
Speaker, Texas House of Representatives  
Members of the Texas House of Representatives  
Texas State Capitol, Rm. 2W.13  
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on Human Services of the Eighty-first Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighty-second Legislature.

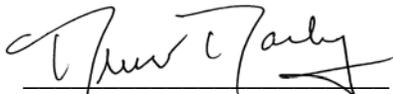
Respectfully submitted,

  
Patrick Rose



Abel Herrero, Vice Chair

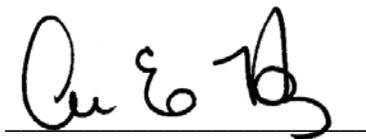
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Armando Walle

[Abel Herrero]  
Vice-Chairman

Members: [Drew Darby, Gary Elkins, Ana Hernandez, Bryan Hughes, Ken Legler, Elliot Naishtat, Armando Walle]

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## INTRODUCTION

On February 12, 2009, the Honorable Joe Straus, Speaker of the Texas House of Representatives, appointed nine members to serve on the House Committee on Human Services for the duration of the 81st Legislature. The following members were named to the committee: Chairman Patrick Rose, Vice-Chairman Abel Herrero, Drew Darby, Gary Elkins, Ana Hernandez, Bryan Hughes, Ken Legler, Elliot Naishtat, and Armando Walle.

Pursuant to House Rule 3, Section 17 (81st Legislature), the Committee has jurisdiction over all matters pertaining to:

- (1) Welfare and rehabilitation programs and their development, administration, and control;
- (2) Oversight of the Health and Human Services Commission as it relates to the subject matter jurisdiction of this committee;
- (3) Mental retardation and the development of programs incident thereto;
- (4) The prevention and treatment of mental retardation; and
- (5) The following state agencies: the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of Family and Protective Services, the Texas State Board of Social Worker Examiners, the Texas Council on Purchasing from People with Disabilities, and the Texas State Board of Examiners of Professional Counselors.

Speaker Straus issued six interim charges to the Committee on November 19, 2009, to study and report back with facts, findings and recommendations. The Committee held three hearings during the 81st Interim Session on March 23, May 13 and June 30, 2010. This report is the culmination of the committee's hearings and investigations.

The Committee wishes to express appreciation to all those who contributed to the interim hearing process and the development of this report including staff from: Chairman Rose's and committee members' offices, the Health and Human Services Commission, the Department of Family and Protective Services, the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of State Health Services, the Texas Workforce Commission, the Texas Department of Housing and Community Affairs, and the Texas Department of Insurance, the Office of the Committee Coordinator, the Office of the Speaker, the Texas Legislative Council, the Legislative Budget Board, and the Legislative Reference Library. Thanks also to members of the public and advocacy organizations who provided testimony at interim hearings and served as a resource to the authors of this report. Finally, special thanks to the Speaker's Senior Health and Human Services Advisor Jennifer Deegan and to the authors of the report Rachel Douglas, Katelyn Blackburn and Kate Mason.

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## HOUSE COMMITTEE ON HUMAN SERVICES

### INTERIM STUDY CHARGES

- CHARGE 1: Monitor the implementation of the Department of Justice settlement agreement, SB 643 (81R), and other reforms to services for persons with intellectual and developmental disabilities.
- CHARGE 2: Monitor the implementation of provisions in SB 2080 (81R) relating to the creation of a permanency assistance program. Evaluate and make recommendations about the foster care licensing process for relatives, the payment structure for a relative who becomes a child's permanent managing conservator, and any factors that should be considered in evaluating program performance and sustainability in the future.
- CHARGE 3: Determine the feasibility of instituting a comprehensive, single point of entry system to simplify and expedite the process of accessing long-term care services for the elderly and individuals with physical disabilities.
- CHARGE 4: Monitor the Health and Human Services Commission's progress toward improving the timeliness of Supplemental Nutrition Assistance Program eligibility determinations. Evaluate the impact of corrective measures already taken by the commission.
- CHARGE 5: Analyze the practice of using informal or voluntary caregivers ("parental child safety placements") during a Child Protective Services investigation. Study and make recommendations regarding:
- a) efforts to track data related to parental child safety placements;
  - b) incorporation of power of attorney authorized by SB 1598 (81R);
  - c) appropriateness of voluntary placement;
  - d) review of caregiver qualifications; and
  - e) potential improvements to the voluntary placement process.
- CHARGE 6: Monitor the agencies and programs under the committee's jurisdiction.

## Charge 1

*Monitor the implementation of the Department of Justice SA, SB 643 (81R), and other reforms to services for persons with intellectual and developmental disabilities.*

### 1. Executive Summary

A 2006 Department of Justice (DOJ) investigation found numerous civil rights violations and avoidable deaths at the Lubbock State Supported Living Center (SSLC), leading the 80th Legislature to invest more than \$120 million in the SSLC system.<sup>1</sup> However, additional reports of abuse and neglect in other SSLCs surfaced and in 2008 the DOJ announced a review of the remaining 12 facilities. That DOJ report found 450 confirmed cases of abuse and neglect and 53 avoidable deaths in fiscal year 2007, stating that the reports of abuse were “disturbingly high” and that more than half of the “state facilities may be in danger of losing Medicaid funding because of care and safety problems.”<sup>2</sup>

The state undertook three significant initiatives in 2009 to reform the system of care for Texas' intellectually and developmentally disabled (IDD) population. First, the Office of the Attorney General (OAG), Department of Aging and Disability Services (DADS), and the DOJ reached a Settlement Agreement (SA) to address the 2008 report's findings. Second, the Legislature passed Senate Bill 643 (SB 643) which required a number of changes to the SSLCs including, but not limited to, video surveillance, increased scrutiny of employees hired, expanded unannounced inspections, creation of the Office of the Independent Ombudsman, and strengthened investigation deadlines and protocols. Senate Concurrent Resolution 77 (SCR 77) appropriated \$45 million to fund the SA and \$19 million to fund SB 643. Third, Section 48, Article II of the 2010-11 General Appropriation Act (SB1) appropriated \$207 million in general revenue (GR) to increase the number of community-based service slots and reduce census at SSLCs by identifying individuals and families that would prefer to receive services in a community setting.

Regardless of these sweeping reforms, reports of abuse, neglect, and questionable practices at Texas' SSLCs continue to surface. DOJ monitors have noted improvements while continuing to cite significant deficiencies. Many of the issues faced by the SSLCs are systemic and will take time to reform. It is possible that the SA, SB 643 and other reforms have not had enough time to make the systemic changes needed to fully reform the system and prevent abuse. These system-wide, overarching issues include staffing shortages, lack of qualified staff, lack of training, and an inability to serve individuals in the most integrated setting possible. The emotionally-taxing, stressful work required of SSLC staff, combined with understaffed SSLCs that often require staff to work overtime, and a lack of trained and qualified staff, are significant factors in the numerous reports of abuse and neglect. As the DOJ's 2008 review found, “until the Facilities can successfully retain, train, and supervise their staff, they will face enormous difficulties in addressing the identified deficiencies.”<sup>3</sup>

Staffing shortages continue to be an issue; registered nurse staffing is at a 84 percent fill rate; physician/psychiatrist staffing is at 77 percent; and occupational, physical and speech therapists are staffed at 78 percent.<sup>4</sup> Encouragingly, direct contact staffing is up from 89.79% on December 31, 2009 to 99.40% on August 31, 2010.<sup>5</sup> There have been slow and steady increases in the number of SSLC residents transitioning to the community. During FY 2008, 206 individuals were moved from SSLCs into the community; 252 individuals moved in FY 2009; 330 individuals moved in FY 2010. The DOJ's monitoring reports indicate, however, that Texas should do more to serve its IDD population in the most integrated setting possible.

SSLCs have three more years to reach full compliance with the 169 provisions of the SA. Based on DADS internal tracking system of progress and compliance with the SA, the SSLCs are anywhere from 1-12 percent in compliance with all 169 provisions.<sup>6</sup> If the SSLCs continue at this rate for the next three years, they will not be in compliance by the SA deadline. **The Human Services Committee has monitored the implementation of these reforms and finds that (a) limited progress has been made toward full compliance with the SA, though the parties stated from the beginning that the changes would likely be slow as they needed to be comprehensive and deliberate; (b) many parts of SB 643 have been implemented, though full implementation will not be realized until at least the fall of 2011; and (c) implementation of Article II, Section 48 of SB 1 is slowly allowing more individuals to receive services in the community.**

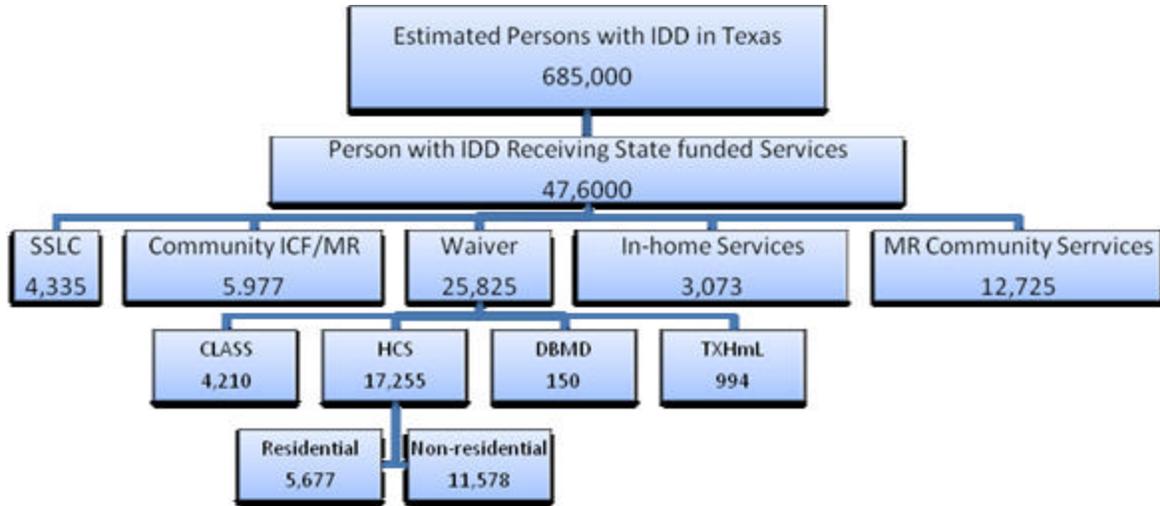
It appears that DADS, SSLC staff, DFPS, and related agencies are doing everything in their power to implement the reforms; the Committee also recognizes that agency and SSLC staff on the ground are more prepared to identify specific changes needed to meet legislative and SA requirement. Therefore, the report's recommendations are not specific to certain provisions of the legislation or SA. However, there is concern that not enough is being done to reform the system quickly enough and that it is possible Texas will not meet the SA deadlines. Therefore, the recommendations are broad in scope and focus on the most prominent issues Texas must overcome in order to ensure it is protecting its SSLC residents.

## **2. Texas' Services for Persons with Intellectual and Developmental Disabilities**

Medicaid-eligible individuals with IDD are entitled to receive care in certain institutional settings, including SSLCs and community Intermediate Care Facilities/Mental Retardation (ICFs/MR). The facilities range in occupancy from 4 persons to a much larger population. Home and community based services, through Medicaid Section 1915(c) waivers, are an alternative to the ICF/MR institutional setting, but are not entitlement programs. States may limit eligibility, the geographical location in which services are provided, the scope and amount of services, and the number of people served. Therefore, some IDD individuals may live in a SSLC because they could not wait for community based services. **Figure 1** below breaks down the number of individuals in each program. As the diagram shows, the majority of waiver recipients are HCS clients.

Ninety-five percent of individuals transferring out of SSLCs between 2000-2007 enrolled in the HCS program.<sup>7</sup>

**Figure 1:** Services to Persons with Developmental Disabilities in Texas, FY 2010



Data Source: Department of Aging and Disability Services

See **Appendix A** for additional information on the costs and monthly caseloads associated with each program.

### 2.1 State Supported Living Centers

Texas currently operates 13 institutions that care for residents with IDD. SSLCs provide 24-hour residential services, behavioral treatment services, health care services, skills training, physical/speech therapy, and vocational services. See **Figure 2** below for a map of the 12 SSLC locations around the state. The Rio Grande State Center has both a mental health and ICF/MR component and is operated by the DSHS through a contract with DADS.<sup>8</sup>

**Figure 2:** Map of the 12 State Supported Living Center & the State Center Locations



Source: Department of Aging and Disability Services

For many decades, institutions were the primary service setting for persons with IDD. More recently, many stakeholders have come to believe that many individuals with IDD can be served more effectively and efficiently in a community setting. As that option is increasingly made available, the institutional census has decreased. The average monthly number of SSLC residents went down from 4,833 to 4,629 between 2008 and 2009, while the average monthly cost went up from \$8,965 to \$10,599.<sup>9</sup> **See Appendix B** for a graph illustrating the census decrease and simultaneous cost increase from 1999 to 2010. **See Appendix C-E** for more information on the individual SSLCs including a breakdown of costs per facility (C), a breakdown of the space and staff available at each facility (D), and a breakdown of the resident population at each SSLC.

### 2.1.1 Mexia SSLC -- Forensic Facility

SB 643 designated the Mexia SSLC a "forensic facility" where juvenile and adult alleged offenders with IDD are treated in two specialized treatment units.<sup>10</sup> Adults found incompetent to stand trial may be involuntarily committed for evaluation or for long-term placement under the Texas Code of Criminal Procedure. Minors may be involuntarily committed for evaluation or long-term placement under the Texas Family Code. Services at this facility are much more transitional because of the type of clients. In 2010, Mexia's admissions accounted for 46.3% of admissions and the largest number of discharges as well.<sup>11</sup>

## **2.2 Immediate Care Facility for persons with Mental Retardation**

An ICF/MR is a residential facility serving four or more people with intellectual and developmental disabilities or a related condition. Section 1905(d) of the Social Security Act created this optional Medicaid benefit to certify and fund these facilities. ICF/MR certification requires aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. ICF/MRs are operated by both private and public entities. Texas' SSLCs are, by definition, ICFs/MR. Over 90% of community ICFs/MR are small (8 beds or less).<sup>12</sup> The average number of persons in ICF/MR Medicaid beds per month decreased from 6,395 in FY 2008 to 6,267 in FY 2009.<sup>13</sup>

### ***2.3 Home & Community-Based Services***

Federal laws allow states to design waiver programs to address the needs of a specific population. A "waiver" is an exception to the usual Medicaid requirements, usually to provide services in home and community-based settings rather than an institution. Medicaid waivers are granted by the Centers for Medicare and Medicaid Services (CMS) under the Social Security Act, §1915(c), and are not entitlements. The costs for the program must cost the same or less than entitlement programs. The following programs waive ICF/MR eligibility: Home and Community-Based Services (HCS), Deaf and Blind with Multiple Disabilities (DBMD), Community Living Assistance and Support Services (CLASS), and Texas Home Living (TXHML). An individual can be enrolled in only one waiver program. Because of the high demand and limited availability for waiver services, DADS maintains interest lists for persons to wait for available services.

The majority of IDD individuals are enrolled in or waiting for HCS services. As of September 4, 2010, there were 7,698 HCS foster care locations serving 8,560 individuals. Family members provide services to 6,032 of these individuals and the rest are taken care of by unrelated persons.<sup>14</sup> **See Appendix F** for a graph illustrating HCS census and cost trends from 1999 to 2010.

## **3. Reporting Abuse, Neglect and Exploitation**

DADS, the Department of Family and Protective Services (DFPS), and the Office of the Inspector General (OIG) play key roles handling allegations of abuse, neglect and/or exploitation (ANE). DADS plays a regulatory role, evaluating facility compliance with state and federal requirements, while DFPS plays the investigatory role. Allegations of ANE are sent directly to DFPS. DFPS notifies law enforcement and OIG of any allegation that may constitute alleged criminal activity.<sup>15</sup> SB 643 required an unprecedented amount of cooperation and communication between agencies to address reports and incidences of ANE.

An Interagency Memorandum of Understanding (MOU) was signed by DFPS, DADS, the Department of State Health Services (DSHS), OIG, the Health and Human Services Commission (HHSC) and Office of the Independent Ombudsman (OIO) on June 2, 2010

to delineate the roles for each agency in ANE investigations. The MOU stated that DFPS would develop a plan by July 31, 2010, to enhance the ability of DFPS investigators to identify allegations of ANE that may constitute criminal conduct and to facilitate reporting to law enforcement and OIG. DFPS enlisted the assistance of staff from the OIG, DADS, HHSC and OIO in reviewing the current training curriculum that instructs MH&MR Investigators on the proper identification of allegations that may constitute criminal conduct. This information is being used to update training curriculum and APS conducted training for all MH&MR investigators in FY 2010 with an emphasis on reporting allegations that may constitute a crime to law enforcement. Additionally, the OIG has begun providing quarterly reports to the Legislature summarizing their SSLC investigations.

### ***3.1 Department of Family and Protective Services***

The Statewide Intake (SWI) allows individuals to make reports by phone, internet, fax, and traditional mail correspondence 24 hours a day, 7 days a week. Within one hour of receiving a report DFPS must notify the administrator of the facility at which the incident occurred. If the allegation may constitute a crime, DFPS must notify law enforcement and OIG within one hour of intake.

Timelines for face-to-face contact with clients are based on the priority level assigned to the investigation. Priority 1 investigations require face-to-face contact within 24 hours. Priority 2 investigations require FTF contact in three days. DFPS amended policy on June 1, 2010 to emphasize the importance of seeing a client face-to-face as soon as possible in a priority 2 SSLC investigation. All SSLC investigations are required to be completed within 10 days of the receipt of the intake unless an extension is approved by the investigative supervisor.<sup>16</sup> In September 2010, 96.3% of SSLC investigations, without an extension, met the new 10-day timeline and 24.8% of the total completed investigations had approved extensions.<sup>17</sup> On June 1, 2010, MH&MR Investigation supervisors began reviewing and approving all SSLC investigations.

Also effective June 2010, APS began reviewing prior case history of alleged victims and alleged perpetrators in all SSLC investigations. The DFPS investigator reviews and analyzes prior case history in all SSLC investigations to determine if the history is relevant to the current investigation. Eight percent of prior case history reviews were used in the investigation; over 80 percent of cases did not use prior case history.<sup>18</sup>

The majority of investigations take place at the SSLCs. Approximately 42.4% (4,121) of investigations in FY 2009 were in SSLCS-- 383 were confirmed. HCS settings made up 22.2% (2,163) of investigations-- with 385 confirmed-- and the rest were in state hospitals, community mental health and mental retardation centers and state centers (Rio Grande and El Paso).<sup>19</sup>

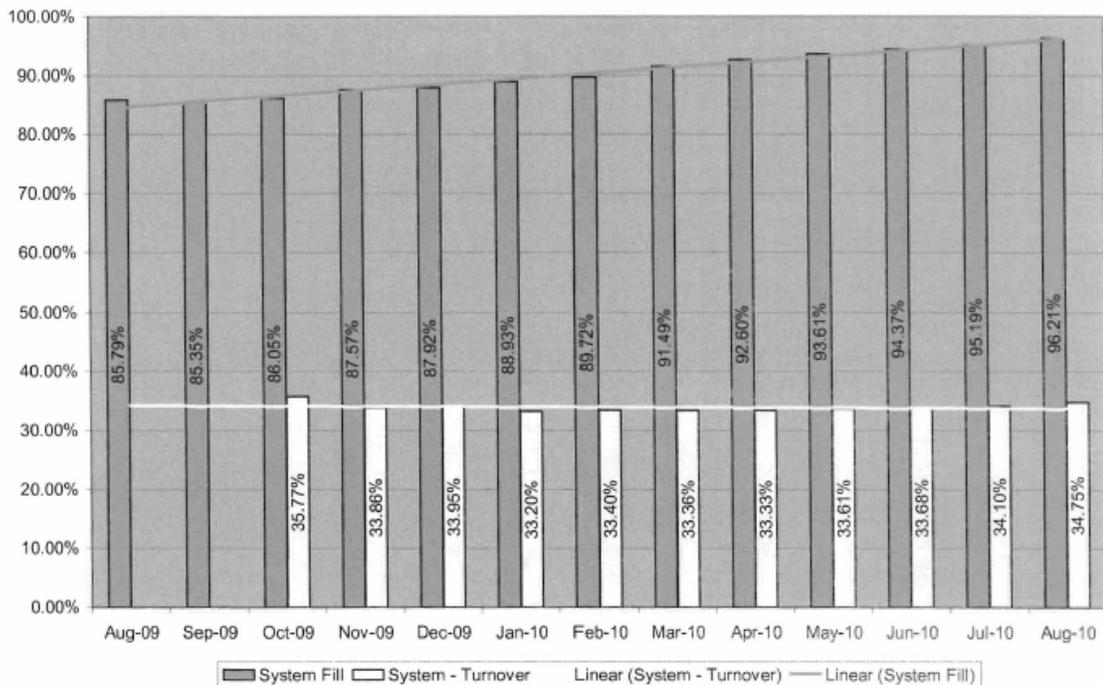
## 4. Overarching State Supported Living Center Challenges

### 4.1 Staffing Shortages

The 2008 DOJ Review found that "frequency and severity of critical incidents at the facilities are disturbingly high and often directly related to insufficient staffing."<sup>20</sup> These shortages are largely due to a widespread shortage of nurses both in Texas and across the United States, shortages of physicians and psychiatrists in rural areas, and high turnover rates at the SSLCs.

The 80th Legislature added an additional 1,690 positions and the 81st Legislature, provided an additional 1,160 staff at the SSLCs to aid in compliance with the DOJ SA for a total of 14,057 budgeted FTEs for Fiscal Year 2010.<sup>21</sup> Additionally, **figure 3** below shows that efforts to recruit staff have helped fill empty positions with the fill rate going up approximately 10% in the last year. Direct contact staffing is up from 89.79% on December 31, 2009 to 99.40% on August 31, 2010. While significant improvements have been realized in filling positions, annualized turnover rates have not improved. It is anticipated that turnover rates will show improvement after first quarter FY2011 data is available on January 1, 2011. However, projections show that turnover rates will worsen at the Lubbock, San Angelo and San Antonio SSLCs.<sup>22</sup> The average tenure for all SSLC employees is 7 years and 8 months.<sup>23</sup>

**Figure 3: SSLC Position Fill and Turnover Rates**



Source: DADS

Turnover data is an annual projected figure based on employment data for the entire fiscal year. Each month's data is cumulative of all previous months in the fiscal year beginning 09/01/2009.<sup>24</sup>

While improvements have been realized, there are still a number of shortages in certain areas. First, while positions may be filled, they are not necessarily filled by full-time staff, but by contracted providers. Ideally, residents would be served by full-time psychiatrists and psychologists who take part in the interdisciplinary team. Second, psychologists, physicians and nurses typically have very large caseloads resulting in more reactive than proactive, preventive health care for residents.<sup>25</sup> DADS has made improvements but still faces staffing challenges in the following areas:

- RN staffing - currently at 86.13%
- Physician/Psychiatrist staffing - currently at 83.99%
- Occupational, Physical & Speech Therapist staffing – currently at 78.85%<sup>26</sup>

**Figure 4** shows the breakdown of staff in each SSLC-- areas with significant staffing challenges are marked with an asterisk. In two of the SSLCs-- Mexia and San Angelo-- there are no speech therapists at all.

**Figure 4: SSLC Staff Breakdown**

Facility	Registered Nurses*		Psychologists**		Occupational Therapists		Speech Therapists		Physicians	
	Total	Filled	Total	Filled	Total	Filled	Total	Filled	Total	Filled
Abilene	79	79	23	22	<b>*6*</b>	<b>*3*</b>	5	3	5	4
Austin	<b>*85*</b>	<b>*71*</b>	17	17	5	5	3	4	4	4
Brenham	<b>*66*</b>	<b>*51*</b>	18	16	3	3	3	3	5	5
Corpus Christi	62.2	58.2	18	17	3	2	2	3	3	2
Denton	<b>*136*</b>	<b>*95*</b>	<b>*22*</b>	<b>*20*</b>	8	8	4.5	1.5	6.5	7.5
El Paso	24	22.6	5	5	2	1	2	1	1.1	2.1
Lubbock	<b>*57*</b>	<b>*38*</b>	12	11	5	3	4	3	3	3
Lufkin	77	71	<b>*18*</b>	<b>*16*</b>	3	3	4	3	4	4
Mexia	84	79	<b>*26*</b>	<b>*23*</b>	4	2	<b>*3*</b>	<b>*0*</b>	4	2
Richmond	111	109	24	23	5.5	5.5	4	3	5	6
Rio Grande	13	10	2	2	1	1	1	1	1	1
San Angelo	<b>*44*</b>	<b>*31*</b>	<b>*26*</b>	<b>*20*</b>	3	2	<b>*2*</b>	<b>*0*</b>	2	2
San Antonio	51	49	<b>*12*</b>	<b>*10*</b>	3	3	3	3	1	1

\*Registered nurses includes both registered nurses and registered nurse trainee positions

\*\*Psychologists include both psychologists and associate psychologist positions

Note: The staffing levels for each SSLC residential home are based on shift-specific needs including: Number of individuals residing in the homes, needs of individuals living at a specific home, and level of supervision for residents.

#### ***4.2 Lack of Qualified Staff***

Lack of sufficient psychological and behavioral specialists is a pervasive issue. There is a significant lack of expertise in applied behavior analysis among various members of some of the Facilities' psychology departments. Some improvements have been noted in the number of certified behavior analysts employed in the facilities and aggressive training and certification of incumbent staff is underway through training at the University of North Texas which has been secured and made available for all psychology staff at each of the SSLCs.

#### ***4.3 Training***

There has not been a significant change in training, as SB 643 simply codified training requirements that were already in place.<sup>27</sup> The training involves two weeks of alternating classroom and on-the-job training to learn both about the various disabilities and to learn "value-based skills".<sup>28</sup> DADS continues to evaluate and expand training for staff to become more competency-based as prescribed in the DOJ Settlement Agreement – those efforts will be continuous and long-term in nature. For training to be considered competency based, it must include return demonstration, meaning the trainee must demonstrate that they are understanding through tests. Significant efforts are underway to assure that all training provided to staff, whether policy-based training or training on implementation of individualized services, is competency-based. SB 643 sets out a requirement for evaluation of training needs in community-based settings and efforts to advance that evaluation and planning for required curricula are actively being pursued at present.<sup>29</sup>

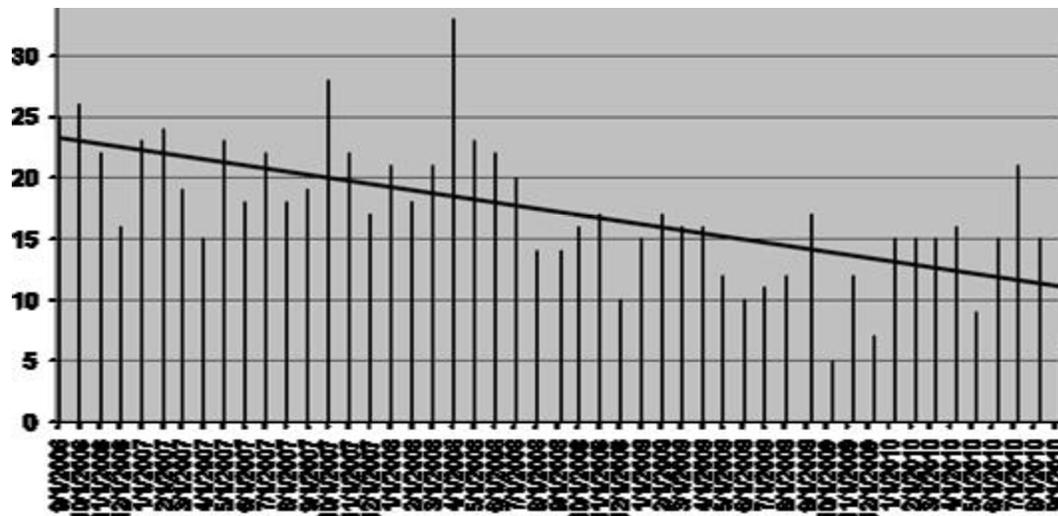
#### ***4.4 Serving Residents in the Most Integrated Setting***

The DOJ 2008 report found that "Texas fails to serve Facility residents in the most integrated setting appropriate to their individualized needs, in violation of Title II of the ADA."<sup>30</sup> Supreme Court Case *Olmstead v. L.C.* (1999) established that States are required to provide community-based treatment for persons with developmental disabilities when the (1) treatment professionals have determined that community placement is appropriate; (2) provided that the transfer is not opposed by the affected individual; and (3) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.<sup>31</sup> Under the Promoting Independence Plan, SSLC residents can avoid interest lists and access HCS waiver services within six months of referral, and individuals residing in large community ICFs can access waiver services within 12 months. This policy effectively produces a loophole to the interest list waiting periods and could encourage temporary institutionalization to avoid longer waiting periods.

The Community Living Options Information Process (CLOIP), implemented January 2,

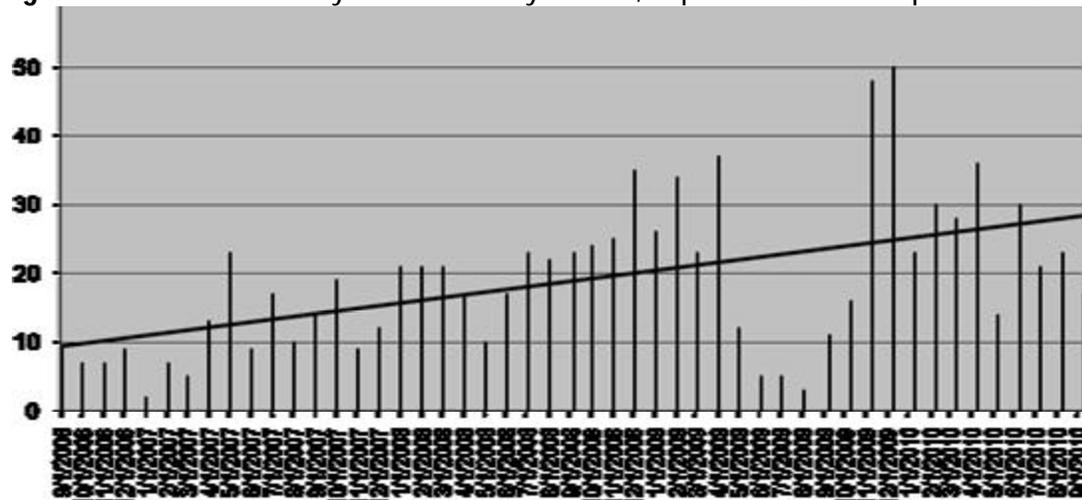
2008, was an initiative to ensure clients are served in the most appropriate setting. CLOIP requires service coordinators at MRAs to conduct an annual, face-to-face meeting with SSLC residents and their legally authorized representative (LAR) to educate and inform them about community alternatives. The CLOIP process is now in place in all areas of the state and the individuals have increasingly moved from the SSLC to the community. During FY 2008, 206 individuals were moved from SSLCs into the community; 252 individuals moved in FY 2009; 330 individuals moved in FY 2010.<sup>32</sup> **Figures 5 and 6** illustrate the drop in SSLC admissions and the increase in community placements. However, there are still many people waiting for services in the community. As of August 2010, there were 32,650 individuals on the CLASS interest list, 316 on the DBMD interest list and 45,756 on the HCS interest list.<sup>33</sup>

**Figure 5: SSLC Admissions Trends by Month, September 2006- September 2010**



Source: Department of Aging and Disability Services

**Figure 6: SSLC Community Placements by Month, September 2006- September 2010**



Source: Department of Aging and Disability Services

Of these community placements, usually no more than one of those placements returns to the SLLC, with two placements being the most that returned in any month.<sup>34</sup>

## **5. Status of DOJ SA Implementation**

### **5.1 Description**

The Civil Rights of Institutionalized Persons Act (CRIPA) of 1980 authorizes the U.S. Attorney General and the Department of Justice (DOJ) to investigate and "seek relief on behalf of residents of public institutions who have been subjected to a pattern or practice of egregious or flagrant conditions in violation of the Constitution or federal law."<sup>35</sup> After a 2008 investigation found numerous violations of residents' civil rights, DOJ, DADS and OAG entered into a Settlement Agreement (SA), effective June 26, 2009. The SA outlines 20 general areas of improvement with a total of 169 specific provisions that must be met. Texas has four years to demonstrate that they have implemented all 20 requirements in all the SLLCs and a fifth year to show sustained compliance before the DOJ will release Texas from the agreement. Monitoring will cease for any provision if a center has achieved substantial compliance for one year. One year has passed, so there are three years left to reach compliance.

As determined by the SA, three Independent Monitors are responsible for monitoring the Facilities' compliance with the SA and related Health Care Guidelines. The monitors were selected on October 7, 2009. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor has assembled a team of 5-7 experts and is responsible for conducting reviews of each of the assigned SLLCs and detailing those findings, as well as recommendations, in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 were considered baseline reviews. The baseline reviews are intended to give the monitors and the state an accurate picture of the starting point for each facility and to identify areas where service delivery improvements are required to reach compliance. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. The Monitor's recommendations are suggestions, not requirements. The Monitors found a number of issues common among all the SLLCs including a lack of integrated individual service plans, incomplete planning for individuals to transition into the community, inability to assess clients' risk levels in a timely manner, medical/nursing staff shortages, lack of experienced staff, lack of psychological care services, and inadequate dental services in some locations.

While the baseline reports were meant to help the SLLCs and DADS recognize significant problem areas; the compliance reports were meant to begin measuring progress in those areas and are a better gage of SA implementation. Monitors are now conducting

on-site reviews of each center every six months. Monitors will produce a written report of each compliance review within 45 days of the visit. Six compliance reports have been issued, with the remaining initial set of compliance reports due over the next few months until January. See **figure 7** below for a schedule of compliance report completion dates.

**Figure 7:** Schedule of Compliance Reviews and Report Completion Dates

<b>Facility</b>	<b>Date of First Compliance Review</b>	<b>Anticipated Date of Release of First Compliance Report</b>
Corpus Christi SSLC	July 12	August 30
El Paso SSLC	July 19	September 6
Brenham SSLC	July 26	September 20
Abilene SSLC	August 2	September 27
San Antonio SSLC	August 16	October 11
Rio Grande State Center	August 23	October 18
Lubbock SSLC	September 13	November 8
Mexia SSLC	September 13	November 8
Denton SSLC	September 27	November 22
Austin SSLC	October 4	November 29
Lufkin SSLC	October 18	December 13
Richmond SSLC	October 25	December 20
San Angelo SSLC	November 15	January 10

DADS Program Improvement Unit, created in April 2007, develops recommendations and monitors the implementation of programs and activities at SSLCs. The Program Improvement Unit has undergone significant modification since November 2009, with the creation of a separate division focused on the coordination of all DOJ SA activities, coordination of all interfaces with the independent monitoring teams, and the handling all logistical measures related to compliance efforts. Unit staff visits the facilities on a regular basis and assists them in all of their coordination activities related to the SA.<sup>36</sup>

**Because the SA was meant to fix structural and systematic problems, it was agreed**

upon by all parties-- DADS, the DOJ and Texas' Attorney General-- that the overall changes would take up to five years to achieve and sustain. In that vein, while some immediate changes have taken place in the facilities, the overall implementation is still largely a work in progress and difficult to measure at this stage.

### 5.2 Implementation Status

According to DADS, corrective actions were initiated for each of the areas identified in the baseline reports, but the improvement process is iterative in nature and not one that focuses on a single action or set of actions so it is often difficult to point to a concrete, specific solution to each problem. Most issues require systematic review of policies, practices and systems and often require corrective actions at multiple levels of the organization. Each facility has a set of improvement initiatives that are consistently being formulated, revised and/or expanded to address areas of improvement necessary to achieve compliance. These plans are almost always multi-phased and longer term in nature.<sup>37</sup> Based on DADS tracking matrices, **figure 8** provides an overview of the scope of progress and compliance towards the SA for each facility.

**Figure 8:** SA Compliance and Progress per Facility, as of September 27, 2010

	Progress	Compliance	Percent Compliance Complete
Abilene	34	18	11 %
Austin			
Brenham	45	2	1 %
Corpus Christi	29	12	7 %
Denton			
El Paso	24	19	11 %
Lubbock		21	12 %
Lufkin			
Mexia	26	12	7 %
Richmond			
Rio Grande	28	12	7 %
San Angelo			
San Antonio	27	21	12 %

Source: Department of Aging and Disability Services

Considering, there are 169 provisions, it is clear that the SSLCs have a long way to go before reaching full compliance. **Again, DADS and the DOJ want the changes to be deliberate and purposeful, but, the slow percentages of compliance completion raises the question whether Texas can reach the SA deadline in the next three years.**

### 5.2.1 The Baseline Reviews

These reviews were not formal compliance measurement efforts, but meant to provide a general overview of each facility and their major challenges. The process included (1) analysis of facility policies, procedures, rules, statutes, and demographic information; (2) an intensive five-day on-site facility visit; and (3) review of all relevant information collected before, during or after the review.<sup>38</sup>

#### **Summary of Findings**

The Department of Justice Monitors identified a number of issues at each of the facilities reviewed. At a minimum, each facility had nine problem areas to address, with two facilities (Lubbock & Rio Grande SSLC) having 15 problem areas to address. In some instances, the monitors prioritized the issues to be addressed initially. The items below identify the issues that were systemic (cited in 11 of the 13 facilities) and those raised in a majority of the facilities.<sup>39</sup>

- *Integrated Individual Service Plans:* There is limited interdisciplinary coordination at the facilities with regard to the formulation of individuals' service.
- *At-Risk Individuals:* Facilities are struggling to assign individuals with the appropriate risk levels; ensure that individuals who are considered at-risk are getting the proper services and supports; or are not assessing individuals' risk levels in a timely manner.
- *Physical and Nutritional Supports:* Facilities were not systematically identifying or addressing individuals with physical and nutritional management concerns such as choking hazards, oral hygiene, or proper medication administration.
- *Planning for Movement, Transition, and Discharge:* Facilities are not properly planning for individuals to transition into the community or are not sufficiently monitoring the impact of the transitions that occur to evaluate whether individuals were provided with adequate supports to transition.
- *Habilitation, Training, Education, and Skill Acquisition Programs:* Skill acquisition programs are inadequate, sometimes with vague goals; individuals had no resources to be active; and some skills assessments were not performed regularly.
- *Residential Direct Care Staffing:* Staffing shortages were a major source of the problems in nursing care, with many facilities utilizing involuntary overtime to maintain adequate staffing. Moreover, inexperienced staff was assigned to work with individuals with complex and challenging needs for support.
- *Psychological Care and Services:* Facilities have insufficient number, and often no, staff with basic knowledge of applied behavior analysis or intervention. Therefore clients' behavior plans were not effective as necessary to adequately address their behavioral needs.
- *Communication:* Facilities were not offering augmentative communication systems to many individuals who needed them or could use them to communicate their basic needs.

- *Pharmacy Services and Safe Medication Practices:* Medication errors were underreported or were reported in an untimely manner.
- *Dental Care:* Because some facilities did not have basic dental services available on site, individuals had poor dental hygiene. For example, at the San Antonio State Supported Living Center, all but two individuals observed at the facility had advanced periodontal disease and poor to non-existent oral hygiene.<sup>40</sup>
- *Use of Restraints:* Although the use of restraints in the last year has reduced at most facilities, there was a 20 percent increase in the use of restraints between July 2009 and February 2010 compared to the same time frame in the previous year at the Mexia State Supported Living Center.<sup>41</sup>
- *Guardianship:* Facilities were not actively pursuing guardians for individuals who need them or had no plan in place for recruiting guardians.<sup>42</sup>

### 5.2.2 Formal Compliance Reviews

These reviews include (1) analysis of facility compliance status updates; (2) An intensive five-day on-site facility visit; and (3) analysis of compliance with the 20 areas of improvement outlined in the SA.<sup>43</sup>

#### **Common challenges identified in compliance reviews include:**

- Need to improve the interface between professional/clinical staff, residential and day program direct services staff, the individual and their family/legal guardian and others who work as a team to plan, organize, implement and evaluate program services for each individual receiving services at the facility.
- Need to enhance functional communication skills development for individuals and use of augmentative communication devices.
- Need to improve competency-based training for all staff responsible for coordination, planning and direct delivery of services.
- Need to more accurately identify the risks and challenges that an individual faces in functioning at his/her greatest level of independence and how services and supports provided by the facility can best support that level of independence.
- Need to increase staffing at all state supported living centers in the areas of dieticians, behavioral services, therapy services and psychiatry.<sup>44</sup>

#### **Improvements in compliance reviews and corrective actions taken include:**

- Staffing improvements in many areas of the facilities' operations have been recognized, especially improvements in residential direct support staffing. The trend for filling vacancies has been moving upwards by approximately a percentage point each month. DADS efforts to recruit and retain staff:
  1. Working with the CareerBuilder staffing recruitment agency
  2. Continued and/or expanded work with nursing schools (both RN & LVN programs) to establish clinical rotations at the SSLCs

3. Discussions with the Texas Tech Health Science Center in Lubbock to seek their assistance in specific recruitment efforts for nurses in both Lubbock and El Paso
  4. Monthly data reports with filled positions/turnover rates now provided to SSLCs.
  5. Both state office and facility staff have increased participation in job fairs and other direct recruitment activities to help link interested individuals with facilities where vacancies exist
- Continued improvement in reduction of restraint usage.
  - Nursing services policies and practices appear to be bringing about improvements in consistency and appropriateness of nursing care.
  - Improvements noted in collaboration between psychology and psychiatry staff.
  - A significant number of psychologist staff members are enrolled and pursuing certification as behavior analysts through coursework at the University of North Texas.
  - All facilities are nearing completion of full implementation of a uniform resident recordkeeping procedure.<sup>45</sup>
  - Implementation of a statewide database to record and track information related to unusual incidents at each facility, including injuries to persons served, allegations of abuse, neglect and/or exploitation and other types of unusual incidents.
  - Expanding the statewide quality assurance program focusing specifically on compliance with the federal Intermediate Care Facilities for Persons with MR (ICF/MR) regulations.
  - Risk identification and amelioration procedures are being refined at each of the facilities to more effectively structure critical services and supports for persons receiving services.<sup>46</sup>

### ***5.3 Issues Specific to SSLCs***

#### **5.3.1 Abilene SSLC**

During the Senate Hearing, DADS said that 25% of ANE cases confirmed were at Abilene. After analysis of data and case specific documentation by DADS and the Abilene SSLC, it was determined that the allegations investigated and confirmed by DFPS in FY08 and FY09 were attributed to the evening shift where there was a high turnover rate of direct support staff and occurrence of less structured activities when individuals are traditionally in their homes. Findings from the trends analysis revealed:

- 24% of the total confirmations since January 2009 involved a breach in the level of supervision.
- 19% of the total confirmations involved staff not providing physician ordered snacks. Two investigations in August 2009 resulted in 31 confirmations of neglect

when staff did not provide physician ordered snacks. This was a significant factor in the investigation confirmations.

- 27% of the confirmations in FY09 resulted from incidents occurring on Tuesday.
- 16% of the confirmations in FY09 resulted from incidents occurring on Thursday.

The Abilene SSLC is taking the following corrective actions:

- Evaluating activities during the evening shift and the need for more structured activities.
- Exploring ways to reduce evening shift turnover.
- Working to safely reduce the number of individuals on enhanced levels of supervision and coordinate with staff on appropriate method to maintain the enhanced levels.
- Providing physician ordered snacks.
- The SSLC State Office Incident Management Coordinator will continue to work with the centers to analyze data and documentation on a monthly and quarterly basis.<sup>47</sup>

### 5.3.2 Mexia, Richmond, Denton, Lubbock SSLCs and the Rio Grande State Center

Mexia SSLC faces challenges planning and following through on community placements and staffing challenges related to the high number of, often unsubstantiated, allegations of ANE. Richmond SSLC failed to consistently follow agency guidelines in the determination of seriousness of injuries. Nursing shortages are a problem for a number of facilities, but especially for Denton SSLC which is only staffed 70 percent and Lubbock SSLC which is staffed 66 percent. There were concerns that the Rio Grande State Center was under-reporting allegations of ANE by staff.<sup>48</sup>

For all of these SSLC-specific issues, DADS stated that no specific actions have been taken to remedy the issue, but that the issues are being addressed as part of the larger improvement plan and that these plans are multi-phased and long-term in nature. It is not clear whether the problem has been resolved at this time.

## **6. Status of SB 643 Implementation**

### ***6.1 Description***

In response to the DOJ report and other publicized reports of abuse, Governor Perry declared state school reform legislation an emergency for the State. Accordingly, the Legislature passed SB 643, authored by Senator Jane Nelson. Generally speaking, this legislation aims to improve resident safety by (1) increasing the standards and training for the staff at the SSLCs; (2) requiring video surveillance of all common areas; (3) creating a new Office of Ombudsman (OIO) to protect the rights of the SSLC residents; (4) designating the Mexia SSLC as a separate facility for "high-risk" alleged offenders; (5)

requiring more thorough screening measures for new employees; and (6) strengthened ANE investigation processes and protocols.

## ***6.2 Implementation Status***

DADS has implemented many of the bill's requirements already-- including random drug testing, fingerprint checks, selection of an Ombudsman and the Assistant Ombudsmen who will be located at each facility. There still needs to be training improvements, increases in staff, and completion of the installation of video surveillance in the facilities. According to DADS, most of these requirements were much easier to achieve quickly than the SA.<sup>49</sup> The elements of the bill-- with a description of the requirements and the progress toward that requirement-- are listed below:

### 6.2.1 Employee and Volunteer Fingerprint checks

SB 643 required DADS and the Department of State Health Services (DSHS) to perform criminal background checks on all agency employees, volunteers, or applicants for employee or volunteer positions. Termination resulted if the check revealed a conviction that would bar employment under chapter 250, Health and Safety Code, which includes murder, kidnapping, sexual offenses, robbery, terroristic threats, injury to a child, elderly or disabled person, and cruelty to animals. Lesser offenses such as assault, burglary, and disorderly conduct would bar employment for five years from the date of conviction.<sup>50</sup>

**Status:** Fingerprinting of all current employees and volunteers was completed as of December 31, 2009 and will continue as new employees and volunteers are hired. Results from the employee fingerprint background checks identified:

- Seventeen SSLC employees who had an absolute bar to employment.
- Nineteen SSLC employees who had a potential bar to employment that, if verified as reported, would become a bar.

Of the 36 employees in these two categories 29 were terminated and seven individuals provided documentation proving that the charges against them were dropped or that there was not a court record of a conviction. DADS drafted a revised criminal history background check policy to be more definitive in its content and with the goal of increased consistency of implementation. The policy includes new crimes that DADS proposes adding to the list of bars to employment and went into effect on September 1, 2010. From September 1, 2009 through July 31, 2010, 232 of 5,530 applicants were disqualified as a result of the fingerprint check.<sup>51</sup>

### 6.2.2 Employee Random drug testing

SB 643 required random drug testing for all SSLC employees and would allow drug testing of a center employee upon reasonable suspicion of the use of illegal drugs. Any employee who knew or reasonably suspected that another center employee was

illegally using or was under the influence of a controlled substance would have to report this knowledge or reasonable suspicion to the center director. Employees could be terminated on the basis of a single positive drug test, but could appeal the decision.<sup>52</sup>

**Status:** Random drug testing is now mandatory for state supported living center employees. Each month the vendor randomly selects 2.1 percent of employees at every facility to test (equates to approximately 250 tests per month statewide). As of July 31, 2010:

- 2,734 employees have been tested
- 53 employees tested positive
- 10 employees resigned in lieu of testing

Employees testing positive or refusing the test were terminated.<sup>53</sup>

### 6.2.3 Employee Training Requirements

SB 643 requires training for the uniqueness of the individuals the center serves, the health and safety of persons with IDD, and the expected conduct of employees. General instruction should include:

- an introduction to intellectual disabilities, autism, mental illness, and dual diagnosis;
- the rights of individuals with intellectual disabilities who are served by the department;
- respecting personal choices made by residents and clients;
- the safe and proper use of restraints;
- recognizing and reporting evidence of abuse, neglect, or exploitation, any unusual incidents, and any reasonable suspicion of drug use, violence, or sexual harassment;
- preventing and treating infection, first aid, and CPR; and
- information regarding home and community-based services, including the principles of community inclusion and the community living options information process (CLOIP).<sup>54</sup>

DADS should develop new training no later than January 1, 2010, and employees should receive new training no later than September 1, 2010. The requirements in SB 643 were already in place, but not in statute. The only course that required additional work was the Self-Determination module.

**Status:** Core training is required for SSLC employees and all training materials have been developed and implemented. Upon review of the training requirements, the Self-Determination module required additional work. It has been improved and is being converted to a computer-based training course. The Self-Determination training module will be completed and distributed for use by January 1, 2011.<sup>55</sup> The self-determination training module focuses on recognition of the abilities of individuals to

actively participate in the development and delivery of services and supports necessary for them.

#### 6.2.4 Training needs

SB 643 required DADS to assess the training needs at private intermediate care facilities for persons with MR and in the Home and Community-based Services (HCS) program. DADS would evaluate and determine the types of training needed and the legislation or actions needed to ensure that the right training was received and would report its findings to the governor and legislative leaders by December 1, 2010.

**Status:** DADS worked with an outside organization to develop a review of training outcomes for direct support workers. DADS worked with Paraprofessional Healthcare Institute (PHI) to assess the training needs in private intermediate care facilities for persons with MR and the Home and Community-based Services (HCS) program. The review was conducted and a report was provided to DADS on October 30, 2009. DADS conducted a provider training needs survey and received feedback from community ICF/MR, HCS, Texas Home Living, Community Living Assistant and Support Services, and Deaf-Blind Multiple Disabilities providers. The provider survey training was completed through an electronic survey tool. DADS is reviewing the results of the survey and will utilize this information in the development of the report that is due by December 1, 2010.<sup>56</sup>

#### 6.2.5 Video Surveillance at SSLCs

SB 643 required DADS to install video cameras in all common areas-- not private areas such as rooms and bathrooms-- of all the facilities. A total of 3,211 cameras will be installed in 335 buildings when the project is complete.

DADS planned to develop a training module, based on experience from Corpus Christi SSLC, by June 2010 for security camera monitors.<sup>57</sup> Training has continued to be provided and modified as necessary with each subsequent roll-out of cameras at each of the facilities. Video training has not been utilized as experience has shown that hands-on training is most effective.

**Status:** Video surveillance cameras are currently operational or in final testing phase at the Corpus Christi, Mexia, San Angelo, Denton, San Antonio, Abilene, El Paso, Lubbock and Lufkin SSLCs. Installation began at the Richmond, Austin, Brenham and Rio Grande facilities in September 2010 and cameras should be operational at these facilities by January 2011.<sup>58</sup>

#### 6.2.6 Forensic Center For High-risk Alleged Offenders - Mexia

SB 643 created a forensic center at the Mexia SSLC for the care of high-risk alleged offender residents apart from other clients and residents. DADS is required to hire

additional forensic center employees and provide training specific to the care of high-risk alleged offender residents to direct care staff. Health and Safety Code (HSC), Section 555.002(b)(5) requires DADS to, "provide training regarding the service delivery system for high-risk alleged offender residents to direct care employees of the forensic state supported living center." Since the effective date of the statute, DADS has made significant progress toward meeting this requirement.

Direct care employees at Mexia are required to attend training offered through the Competency Training and Development Department (CTD). CTD maintains a strict attendance and grading policy to ensure that staff complete the coursework and demonstrate mastery of the content. In addition to the standard SSLC training, staff in the forensics unit are also encouraged to complete "MR-5: Issues In Dual Diagnosis, Juvenile and Adult Offenders." This course, which carries 3 hours of college credit at Navarro College, meets three hours a week for sixteen weeks. To date, 66 Mexia staff have completed this course. Topics in this advanced training include:

- the diagnosis, assessment, and evaluation of Mental Retardation and Mental Illness in people with Mental Retardation;
- legal rights such as confidentiality, due process, and least restrictive alternative;
- Family Code §55.03 regarding court committals and how it relates to competency and culpability;
- relevant sections of the penal code;
- drug and alcohol use by those with Mental Retardation;
- placement options;
- gang-related activities;
- IDT planning;
- treatment issues related to psychology, habilitation, vocational education, social and leisure skills, and medication;
- communication; and
- PMAB, Gentle Teaching, and crisis intervention.

Additionally, CTD staff at Mexia are currently in the final stages of development of an additional four-hour course to be provided specifically to those staff who work in the forensic program. Further development in this area of training will be an ongoing function of CTD.

Before a transfer takes place, current alleged offender residents classified as high risk are entitled to:

- an administrative hearing with the department to contest the determination and classification;
- bringing suit to appeal the determination and classification in district court in Travis County, upon exhausting administrative remedies with DADS;
- and an administrative hearing to contest the proposed transfer or discharge.<sup>59</sup>

Alleged offender residents determined not to be high risk and non-alleged offender residents in the Mexia SSLC can remain at the facility, housed separately from the high-risk alleged offender population, or transferred to another SSLC. DADS initially houses all new alleged offenders at Mexia until a risk determination is completed. Within 30 days of a new alleged offender resident arriving at the forensic SSLC and annually thereafter, an IDT should determine whether the alleged offender was high-risk.<sup>60</sup>

**Status:** Target date for full implementation of the statutory requirements is August 2011.<sup>61</sup> A detailed plan of action and timelines have been developed for:

- Identifying and transferring residents from other facilities to the forensic facility;
- Placing high-risk alleged offenders in separate homes based on age and gender;
- Placing alleged offenders in the facility when initially committed for evaluation;
- Transferring non-offender and low-risk alleged offender residents who request a transfer from the forensic facility; and
- Providing specialized training to direct care staff at the forensic facility regarding service delivery for high-risk alleged offenders

Specific timeframes for each of these actions has not been established as each is somewhat interdependent with the other. The current plan of action is focused on evaluation and transition of individuals from Corpus Christi and working through the statutorily required appeals process. Once these first experiences are fully accomplished, evaluation at each of the other facilities will be undertaken and transition will occur as laid out on an individual, case-by-case basis. Transfer options for persons from Mexia to other facilities have been offered but no specific recommendations have been identified to date. This is an ongoing process that is an element of each individual's annual program planning process as is mandated by ICF/MR regulations and the elements of the SA.<sup>62</sup>

The plan for modifications to the physical plant required to implement the forensic facility have been completed and funding has been secured. The projects are in the design/development phase and work should commence just after January 1, 2011.

DADS continues to evaluate the feasibility of recertification of four homes at the Mexia facility that are not certified currently. Ten years ago, these four homes were decertified in response to a loss of ICF/MR certification at the facility related to provision of certain highly-restrictive behavioral services and supports for a small number of individuals. DADS now believes re-certification is possible and anticipates that final dispensation of this plan will not occur once the forensic program is fully implemented around the fall of 2011.<sup>63</sup>

After identification of an appropriate assessment instrument to be used in determining whether an individual admitted under criminal commitment is "high risk" was made, individuals at Corpus Christi SSLC were assessed both by staff at Corpus Christi and then separately by staff at Mexia. From that assessment, five individuals were determined to be "high risk" and a recommendation for transfer of those individuals from Corpus Christi to Mexia was made. Consistent with statutory provision, each of these individuals has a due process right to appeal that determination and each has done so. Due process hearings to consider these appeals are currently pending at the Health and Human Services Commission Office of Administrative Hearings. Once the appeal decisions are made, similar assessments will be completed for other alleged offenders at the remaining SSLCs.

As of 9/30/2010, there were 233 alleged offenders at Mexia SSLC. High-risk assessments have not yet been conducted at Mexia.<sup>64</sup>

#### 6.2.7 Serious Event Definition and Notification Protocol

Workgroup composed of SSLC residents, residents' family members/legally authorized representatives, and DADS staff met on November 6, 2009, to identify information to be included in the definition. A draft definition was developed and provided to stakeholders at each of the state supported living centers to solicit input and feedback. The final policy containing the definition and contact requirements became effective on September 1, 2010.<sup>65</sup>

#### 6.2.8 Office of the Independent Ombudsman

The OIO was established for the purpose of investigating, evaluating, and securing the rights of residents of the SSLCs and the ICF-MR component of the Rio Grande State Center. The mission is to "To serve as an independent, impartial, and confidential resource; assisting our clients, their families, and staff at SSLCs, advocates, guardians, and the public with services, complaints and issues which deal with the SSLCs".<sup>66</sup> The OIO is administratively attached to DADS, but is independent of DADS.

The bill required the Governor to appoint as ombudsman an individual with at least five years of experience in the IDD field, no later than September 1, 2009. The role of the ombudsman is to evaluate how centers investigate, review, and report unusual incidents and injuries and to evaluate center services to ensure the rights of residents and clients were protected and that sufficient unannounced patrols were conducted. Under the bill, the ombudsman would refer complaints of: possible abuse, neglect, or exploitation to DFPS; unusual incidents to the inspector general; and ICF-MR standards violations or employee misconduct that did not involve abuse, neglect, or exploitation to the regulatory division of DADS.<sup>67</sup>

The ombudsman is not required to investigate alleged criminal offenses or alleged abuse, neglect, or exploitation of a resident or client, but is required to investigate complaints involving a possible systemic issue in a developmental center's services and could apprise a person who was interested in a resident's or client's welfare of the respective rights of the individual. The ombudsman takes action upon determining a resident, client, family member, or LAR was in need of assistance, including advocating with an agency, provider, or other person in the best interests of the resident or client and making appropriate referrals. SB 643 requires that the independent ombudsman:

- conduct an annual audit of each center's policies, practices, and procedures to ensure that each resident and client was encouraged to exercise his or her rights, including the right to file a complaint and the right to due process;
- and prepare and deliver an annual report regarding the findings of each audit to various state leaders and agencies.<sup>68</sup>

The bill requires the OIO to promote awareness of the services provided by the office and how it could be contacted. OIO is required to establish a permanent, toll-free number to report a violation of resident rights. On the effective date of the bill, a DADS employee who performed duties primarily related to consumer rights and services at state centers would be required to reapply for a position with the department and could apply for a position as an assistant ombudsman.<sup>69</sup>

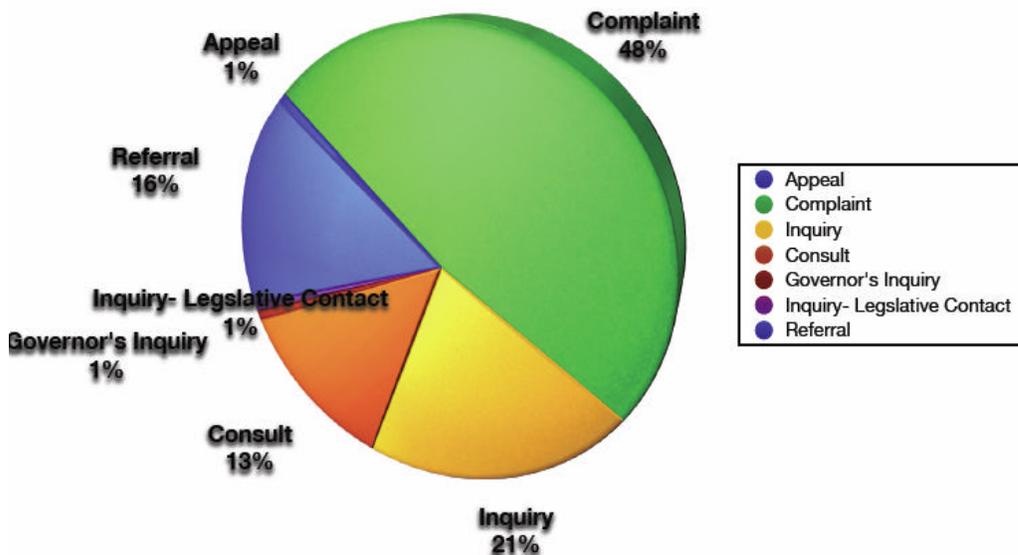
**Status:** On February 11, 2010, Governor Rick Perry appointed George Bithos as the Independent Ombudsman for SSLCs.<sup>70</sup> Ombudsman Bithos has hired assistant ombudsmen to be based out of each of the SSLCs. The Denton SSLC has been assigned two Ombudsmen due to its resident population. Originally, Human Rights Officer positions were to be eliminated 30 days after the assistant ombudsman position is filled at their center. However, DADS decided to keep the positions because their roles and responsibilities are significant to comply with ICF/MR conditions of participation. Initially, the resources necessary to establish the functions of the independent ombudsman were drawn from these positions; however, a large majority of the functions of the human rights officer are not related at all to the current functions of the ombudsman and each of these functions is a required element of compliance with ICF/MR conditions of participation. Therefore, DADS reestablished positions for a human rights officer at each of the SSLCs and all of these positions have been filled.<sup>71</sup>

In September, OIO staff participated in a training that included overview of the Policy and Procedures Manual, overview conducting an audit/program review by guest speaker Penny Rychetsky of Internal Audit, overview of DFPS process by guest speaker Beth Engelking, Assistant Commissioner at DFPS, and HEARTS Reporting instructions.<sup>72</sup>

In September, HHS Enterprise Administrative Report and Tracking System (HEART) was customized to include an external interface to capture survey and complaint from website directly to HEART. Tailored to include the needs of the OIO and produce qualitative and quantitative reporting which will assist in the mandated reporting.<sup>73</sup>

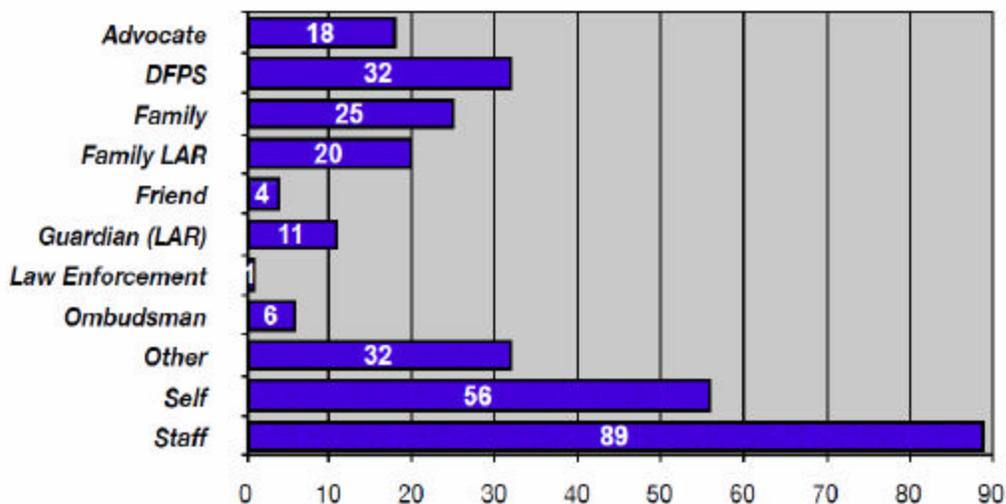
The Independent Ombudsman's first Annual Report was released September 2010. **Figures 9 and 10** illustrate two months of activity for the Office and show that almost half of the contacts have been complaints; the majority of contacts have been from staff; and Richmond, Mexia, and Abilene have contacted the Office the most.

**Figure 9:** Office of the Independent Ombudsman Type of Contact Breakdown



Source: Office of the Ombudsman, 2010 Annual Report  
Generated using data from HEART July 2010 & August 2010

**Figure 10:** Source of Inquiries, Referrals, Complaints to the Ombudsman



Source: Office of the Ombudsman, 2010 Annual Report  
Generated using data from HEART July 2010 & August 2010

Additionally, the Ombudsman's Office has set up a toll-free number, confidential fax numbers, and a website. For the month of September, there were 2116 hits to the website with the majority of visits to the 2010 Annual Report and the homepage.<sup>74</sup> The Ombudsman's website is currently being translated into Spanish and is scheduled to be available November 15, 2010. To promote awareness of the office, posters in Spanish and English have been placed in the common areas of all the SSLCs. There is a brochure in Spanish and English in production.

#### 6.2.9 Assistant Commissioner for State Supported Living Centers

SB 643 required DADS commissioner to hire an assistant commissioner of SSLCs whose duties would include: supervising the operation of the SSLCs; verifying that quality health and medical services were being provided; verifying and certifying qualifications for employees of SSLCs; working with the commissioner to create administrative guidelines for proper implementation of federal and state statutory law and judicial decisions; and consulting with DSHS to ensure that individuals with dual diagnosis residing in state centers were provided with appropriate care and treatment.<sup>75</sup>

**Status:** Chris Adams was hired as the Assistant Commissioner for State Supported Living Centers, effective November 16, 2009.<sup>76</sup>

#### 6.2.10 Annual Unannounced Inspections

SB 643 requires unannounced on-site surveys of all HCS group homes in the state. Previously, DADS surveyed a sample of group homes each year, but not all.

**Status:** Reviews began mid-September 2009. 20 additional surveyors have been hired and assigned regionally across the state. As of July 31, 2010, 8,586 annual reviews of home and community-based services (HCS) homes were conducted; including 6,745 foster/companion care homes and 1,841 three- or four-person group homes.<sup>77</sup> As of October 26, 2010, there are 8,954 individuals receiving HCS Foster Care and, 6,441 of those are served by a family member.

On January 15, 2010, Representative Rose sent a Letter to Commissioner Chris Traylor clarifying the intent of the legislation, which was to survey both HCS group homes and foster homes. The Letter of Intent explained that SB 643 did not mention HCS foster homes because of funding uncertainties, but that foster homes were eventually included under the intent of the unannounced visits in SB 643 as they were funded as an exceptional item in SB 1.

9,663 residential reviews were conducted in FY2010. 6,819 locations were open the entire period from 09/01/2009-08/31/2010, thus requiring review to meet legislative directives. 6,800 of these residences were reviewed in FY2010. The additional reviews

reflect locations that have closed or opened during the FY. The following resulted from the reviews:

7,704 Foster/Companion Care Setting Reviews

1,207 (13.3%) required evidence of correction

55 (0.7%) required immediate action due to significant risk

1,959 Three- or four person HCS Group Home Reviews

219 (11.18%) required evidence of correction

28 (1.43%) required immediate action due to significant risk

**Figure 11** lists the most common issues identified during the unannounced visits.

**Figure 11:** Top Ten Issues from June- August Residential Unannounced Visits (2248)

Rank	Times Identified	% of Reviews Identified	Residential Review Issue
1	634	28.20%	Do emergency plans reflect the special needs of the individual(s) who live here?
2	606	26.96%	Have fire drills been conducted as required during the past year?
3	563	25.04%	Is an emergency evacuation plan available and appropriate to the location of the home?
4	478	21.26%	Are medication administration records available and completed accurately?
5	282	12.54%	Is the Legal posting for the provider present and in view?
6	267	11.88%	If there are any cats/dogs at the home, do they have current vaccinations?
7	195	8.67%	Are there adequate, fully charged fire extinguishers accessible to the kitchen, utility room and garage?
8	169	7.52%	Do staff know the requirements for reporting abuse, neglect and exploitation?
9	154	6.85%	Are there adequate working smoke detectors installed?
10	116	5.16%	Are emergency numbers readily available?

During FY 2010, DADS received 2,168 feedback cards for the residential reviews with 1,237 cards containing positive feedback and 55 containing negative feedback.<sup>78</sup>

6.2.11 Investigation of Abuse, Neglect and Exploitation

SB 643 requires DFPS, instead of DADS, to receive and investigate reports of abuse, neglect and exploitation at private ICF/MRs. The bill requires private facilities to prominently post a notice of how to contact DFPS to report allegations. Private ICFs-MR are required to report employee misconduct of abuse, neglect, and exploitation. DFPS, within one hour of receiving a report of abuse, neglect, or exploitation in a private ICF/MR, should notify the private ICF/MR in which the individual was receiving services

of the allegations and forward a copy of the initial intake report to local law enforcement for evaluation and investigation if DFPS believes the allegations may constitute a crime.

**Status:** DFPS began receiving and investigating reports of abuse, neglect and exploitation at private ICFs/MR on June 1, 2010.<sup>79</sup> As of September 2010, DFPS has received 433 intakes regarding allegations of abuse, neglect or exploitation in private ICFs/MR. Upon receipt of a report from DFPS or OIO, OIG must determine, within 24 hours, whether a criminal investigation is warranted and report that determination to DFPS or OIO for further investigation by the agency.<sup>80</sup>

Unlicensed employees in private ICF/MR have been subject to the Employee Misconduct Registry (EMR) and DFPS forwards confirmed findings of ANE that rise to the level of reportable conduct to DADS. Employees are forwarded to DADS for placement on the EMR once they have received due process or waived their right to due process. The EMR also applies to unlicensed staff who work for a Home and Community Support Services Agency (HCSSA) or HCS Waiver program, and effective September 1, 2010, SSLC, state center, community centers, state hospitals, MHA and MRA employees. Placement on the EMR is a permanent bar to employment in certain facilities or agencies.

If a report regarding abuse, neglect or exploitation in an SSLC contains allegations that rise to the level of a crime, DFPS must notify the OIG as well as local law enforcement. Upon receipt of a report from DFPS or OIO, OIG must determine, within 24 hours, whether a criminal investigation is warranted and report that determination to DFPS or OIO for further investigation by the agency.<sup>81</sup> The DFPS completed investigation report is sent to the OIG and local law enforcement regardless of the findings.

DFPS is responsible for working with the OIO when the OIO reports allegations of abuse, neglect or exploitation of an SSLC resident. DFPS is also responsible for sending a copy of the completed investigation to the OIO when the OIO reported the allegations to DFPS. DFPS works cooperatively with the OIO when there is a need to exchange information about an investigation of abuse, neglect or exploitation that was conducted by DFPS in an SSLC.

In FY2009, APS completed 9,730 MH&MR abuse, neglect, and exploitation (ANE) investigations. Out of this total, 10.8% (1,049) of investigations were confirmed, 47.1% (4,579) were unconfirmed, 7.9% (773) were inconclusive, 6.5% (630) were unfounded and 27.7% (2,699) were other (not ANE-referred back to facility). These investigations took place in five settings: State Supported Living Centers (formerly State Schools), State Hospitals, Home and Community Services (HCS) waiver settings, Community Centers, and State Centers. Over 90% of all investigations were in state schools, state hospitals, or HCS settings.

### 6.2.12 Mortality Review

SB 643 requires DADS to create an independent mortality review system to review deaths of individuals who at the time of the death were: a resident in or received services from a state center, an ICF-MR operated or licensed by DADS, or a community center; a resident in a 1915(c) waiver program group home serving three or more developmentally disabled individuals, and in which the waiver program provider had a property interest. The executive commissioner, no later than December 1, 2009, would be required to contract with an independent, federally certified, patient safety organization (PSO) to conduct mortality reviews.<sup>82</sup>

**Status:** HHSC contracted with a selected PSO to conduct mortality reviews. The SSLCs will be required to submit data to the PSO. Federal law prohibits DADS from imposing mandatory reporting to the PSO by private sector providers (i.e., licensed ICFs/MR, HCS and DBMD waiver program providers). Therefore DADS will implement a process by which we can meet the intent of legislation by conducting internal mortality reviews for these programs:

- HCS: DADS established a Death Review Group (DRG) in 2008 to conduct mortality reviews of persons served in the HCS waiver program.
- DBMD: As there are a relatively small number of deaths each year in the DBMD waiver program, DADS will conduct DBMD death reviews using the existing DRG; and
- Licensed ICFs/MR: DADS will facilitate and coordinate a new mortality review committee with existing resources to create a mortality review procedure for licensed ICFs/MR.

### 6.2.13 Memorandum of Understanding

SB 643 requires a Memorandum of Understanding (MOU) between HHSC, DFPS, DADS, OIO, and OIG by December 1, 2009, regarding investigations of abuse, neglect, or exploitation in state centers and delineating the responsibilities of each agency.

**Status:** This has been completed and the aforementioned agencies are now working together regarding ANE investigations.

### 6.2.14 Investigation Database

SB 643 requires DADS, in consultation with DFPS and the OIG, to develop and maintain an electronic database to collect and analyze information on the investigation and prevention of ANE of persons with IDD residing in publicly or privately operated ICFs-MR or in HCS group homes, other than foster homes. The information in the database should be detailed, easily retrievable, and include information on abuse, neglect, and exploitation investigations and regulatory investigations.<sup>83</sup>

**Status:** Preliminary analysis of relevant existing data sources underway at DADS and DFPS. DADS has prepared a statement of work which details the work and all of the deliverables to be provided by the selected vendor to implement and build the database. DADS began accepting vendor responses in June 2010.<sup>84</sup>

By bringing together data from DFPS and DADS, the new database will allow for more accurate and timely analysis and reporting of abuse, neglect and exploitation data for state supported living centers, private intermediate care facilities for persons with intellectual disabilities and home and community-based services group homes as well as regulatory investigations and surveys. DADS has procured a vendor to create the database and new reports. The project kickoff is scheduled for October 19, 2010, and planned implementation is in December 2010.

#### 6.2.15 Increased penalties

SB 643 would increase penalties for failure to report the abuse of a child from a Class B misdemeanor to a Class A misdemeanor. The penalty for knowingly failing to report the abuse, neglect, or exploitation of an elderly or disabled person increased from a class A misdemeanor to a state-jail felony. The penalty for intentionally and knowingly committing an injury to a disabled increased from a third-degree felony to a second-degree felony.<sup>85</sup>

#### 6.2.16 Interim Select Committee

SB 643 established the Interim Select Committee on Criminal Commitments of Individuals with Mental Retardation to study the criminal commitment process for individuals with mental retardation who were found incompetent to stand trial or who were acquitted by reason of insanity. The committee's study should include:

- the advantages and disadvantages of the existing system;
- the number of individuals with mental retardation who were criminally committed each year and the number found to be violent or dangerous through the criminal commitment process;
- whether the commitment process should be changed to provide for the commitment of individuals with mental retardation found to be violent or dangerous to a mental retardation facility instead of to a mental health facility; and
- the costs associated with modifying the criminal commitment process.

The committee should include the chairs of various legislative committees and would report its findings to the governor, the lieutenant governor, the House speaker, and legislators by December 1, 2010.

## **7. Status of Other Reforms: Article II, Section 48, SB 1**

### **7.1 Background**

In June 1999, the US Supreme Court ruled in *Olmstead vs. L.C.* that unnecessary institutionalization violates the ADA. States must provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when:

- The state's treatment professionals determine that such placement is appropriate;
- Affected persons do not oppose such treatment; and
- Placement can be reasonably accommodated, after considering the resources available to the state and the needs of others receiving state supported disability services.<sup>86</sup>

In 2002, Governor Rick Perry issued executive order RP-13, directing the HHSC to review and correct state policies that create barrier for individuals wishing to move from an institutional setting to the community, among other thing. The 79th Legislature appropriated \$97.9 million in General Revenue funds to DADS to reduce the number of individuals on interest lists and \$71.5 million during the 80th Legislature.

In recent years, increasing the service and living options for individuals with intellectual and developmental disabilities is an issue that has received considerable attention from both the U.S. Supreme Court and the Texas Legislature. However, Texas still relies heavily on institutionally based service delivery.

Because the demand for DADS community-based services often outweighs available resources, applicants' names are placed on an interest list until services are available. The waiver programs for individuals with IDD are Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), and Home and Community-Based Services (HCS).<sup>87</sup> These programs have very large interest lists. Article II, Section 48, of the 2010-2011 Appropriations Act represents an attempt to address this potential imbalance and to serve more individuals in the community where appropriate.

### **7.2 Description of Article II, Section 48, SB 1**

Section 48, SB 1, "Contingency Appropriation for Reshaping of the System for Providing Services to Individuals with Developmental Disabilities" is recognized by some advocates as one of the biggest steps Texas has taken to promote community-based service delivery. It required DADS to increase the number of waiver slots during FY 2010 and 2011 and utilize census management to reduce the number of SSLC residents. It states that, "costs of serving reallocated residents be financed through reduced expenditures for the operation of state schools." It also transferred case management functions from HCS Waiver program providers to MRAs.

Section 48 directs \$207 million in appropriated general revenue and \$256 million in appropriated federal funds to reduce waiver-related community slots by 7,832 by August 2011. Of the 7,832 slots created by Sec. 48, 196 were meant to divert people from admission to the SSLC for the biennium (100 for children and 96 for adults). The diversion slots refer only to HCS. The following lists the number of slots appropriated, the number of people who have moved to the community, and the number of people still on the interest lists:

	Appropriated FY 2010 (Sec. 52)	Appropriated Slots end of FY 2010 (Sec. 52)	Affordable slots end of FY 2010	# of Appropriated Slots filled as of August 2010	# on Interest List as of August 2010
CLASS	18.9 mil.	945	343	225	32,650
HCS	67.8 mil.	2,968	3,206	2,859	45,756
DBMD	0.1 mil	3	(22)	(22)	316

TxHmL did not receive funding for additional waiver slots for FY 2010-11.

### **7.3 Implementation Status**

As of October 1, 35 children and 32 adults have completed the enrollment process and 37 children and 41 adults have been authorized for enrollment.<sup>88</sup> The opportunity to use HCS as a diversion from admission to SSLC is offered to everyone who seeks admission, but more adults have accepted that opportunity than have families of children. Some have speculated that this is the result of more adults than children seeking SSLC admission. DADS anticipates fully utilizing the appropriation by the end of the biennium. Service delivery cost increases may cause DADS to serve fewer people than assumed in the General Appropriations Act.<sup>89</sup>

#### 7.3.1 Census Management

- DADS staff reviewing current population at each facility and historical trends in the number of residents.
- MRAs are continuing CLOIP to assure all individuals and their families or legally authorized representatives are provided relevant information about available community placement alternatives.
- Reviewing the existing processes and procedures to identify trends and patterns of transition of individuals from SSLCs to the community.
- From August 31, 2009 through July 31, 2010, the number of persons served in SSLCs has declined from 4,541 to 4,228 (6.9%).
  - 315 individuals have moved to the community during FY2010.<sup>90</sup>

### 7.3.2 Additional Waiver Slots

- Allocation of additional waiver slots for persons at risk of institutionalization in ICF/MRs.
- Slots are available at a rate of four per month.
- As of August 1, 2010, 37 children and 41 adults have been authorized enrollment into these slots.<sup>91</sup>

### 7.3.3 Study of Managed Health Care

Requires a study of managed care for persons with intellectual and developmental disabilities. HMA submitted their draft report on October 15, 2010 to HHSC. HHSC will submit the final report to the Legislature by December 1, 2010, as mandated by Section 48.<sup>92</sup>

### 7.3.4 Transfer of Case Management Functions

Section 48 directed the transfer of case management functions from home and community-based services providers to MRAs. As of June 1, 2010, the case management functions for persons enrolled in the HCS program transferred from HCS providers to the MRAs. As of August 2, 2010, 18,442 individuals served in the HCS program were assigned a service coordinator from their local MRA.<sup>93</sup>

DADS staff has maintained contact with local authority representatives and with private provider organizations to address any issues with implementation. Some issues have been identified as a source of confusion including how plan of care revisions take place and how transfers between providers take place. DADS is addressing these issues through revised procedures, modifications to the CARE data system and technical assistance. DADS is hosting a workgroup made up of private provider representatives, advocacy groups and the Texas Council of Community MHMR Centers to meet monthly and continue to address implementation concerns.<sup>94</sup>

## **8. Recommendations**

- (1) Evaluate ways to speed the process for achieving Settlement Agreement compliance to ensure SSLC resident safety and civil rights, and that the SSLCs meet the SA deadline.

It should be noted that the SA's timeframe is approximately half the time that other states have been provided to reform their systems (usually 8-10 years). Attempts to rush this process without the proper supports and protocols could result in inadequate or incomplete system change and longer-term litigation costs.

- (2) Clearly delineate the role of the Office of the Independent Ombudsman.

Currently, the Client Rights Officers and Human Rights Committees have some overlapping roles/functions with the Ombudsmen. Since the Ombudsman role is new, as established by the legislature through SB643, there may be the necessity to provide more clarity on their roles.

- (3) Consider revising statute and agency policy to ensure that foster care providers are aware of their right to request a visit at another time during unannounced visits.
- (4) Consider revising statute to clarify that unannounced visits were intended in foster care settings. Amend Subchapter D, Chapter 161, Human Resources Code, Section 161.076 by removing the words "other than a foster home."
- (5) Improve interdisciplinary team communication. Consider implementing a facilitator who makes sure all team members are communicating and working together in the best interest of the client.
- (6) To reduce turnover, implement improved training modules and consider producing a "realistic job preview" video that shows applicants what to expect in the job.
- (7) Implement strategies for hiring and retaining registered nurses, psychologists, occupational therapists, speech therapists, and behavioral specialists.

## 9. Endnotes

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- <sup>3</sup> Statewide CRIPA Investigation of the Texas State Schools and Centers. Dec. 1, 2008. Online. Available: [http://www.justice.gov/crt/split/documents/TexasStateSchools\\_findlet\\_12-1-08.pdf](http://www.justice.gov/crt/split/documents/TexasStateSchools_findlet_12-1-08.pdf). Accessed October 6, 2010. p. 5
- <sup>4</sup> DADS PowerPoint Presentation to the Senate Committee on Finance, Charge 10. Presented by Commissioner Chris Traylor. August 18, 2010. p. 14.
- <sup>5</sup> E-mail from Carol Sanchez-Cuellar, DADS Government Specialist, to Katherine Mason including notes from *10/14 HHSC Key Staff Briefing presentation*. Oct. 11, 2010.
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- <sup>13</sup> The Department of Aging and Disability Services *Reference Guide*.
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- <sup>15</sup> E-mail from Carol Sanchez-Cuellar to Katherine Mason. Oct. 18, 2010.
- <sup>16</sup> E-mail from Carol Sanchez-Cuellar to Katherine Mason. Sept. 29, 2010.
- <sup>17</sup> E-mail from Ann Strauser to Katherine Mason including internal document from Department of Family and Protective Services, "Completion of Major Senate Bill 643 and Department of Justice Settlement Agreement Activities". September 29, 2010.
- <sup>18</sup> *Id.*
- <sup>19</sup> E-mail from Carol Sanchez-Cuellar. Sept. 29, 2010.
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- <sup>21</sup> *Id.*, p. 19.
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- <sup>52</sup> House Research Organization, Bill Analysis for SB 643, p. 5.
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- <sup>56</sup> Id., p.4
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- <sup>78</sup> April 8, 2010 Letter from DADS Commissioner Chris Traylor to Chairman Patrick Rose, p.2.
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- <sup>87</sup> The Department of Aging and Disability Services *Reference Guide*. Online.
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- <sup>91</sup> Id.
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**10. Appendices**

**Appendix A**

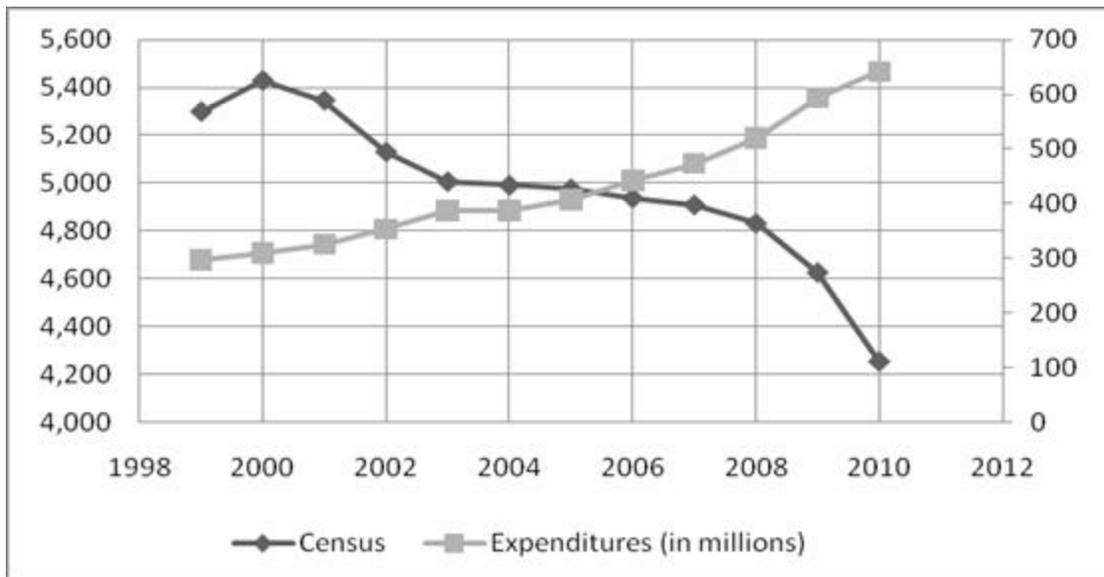
FY 2010 Cost and Caseloads from FY 2012-13 LAR

	Average # of Clients/month	Average Monthly Cost/client	Average Daily Cost/client
<b>Waiver Programs</b>			
HCS	17,255	\$ 3,534	\$ 116
CLASS	4,210	\$ 3,650	\$ 120
DBMD	150	\$ 4,082	\$ 134
TXHmL	994	\$ 697	\$22
<b>Entitlements</b>			
Licensed ICF/MRs	5,977	\$ 4,525	\$ 148
SSLC	4,335	\$ 12,333	\$ 405

Source: Department of Aging and Disability Services, Sept. 2010

**Appendix B**

SSLC Census and Appropriations, FY 1999 to 2010



Source: Department of Aging and Disability Services

## Appendix C

### Break-down of SSLC Costs, FY 2007

STATE SCHOOL	CLIENT CARE	COMPREHENSIVE MEDICAL	ADMINISTRATIVE	QUALITY ASSURANCE FEE	OTHER	TOTAL
Lufkin State School	\$155.91	\$37.15	\$65.59	\$18.18	\$29.97	\$306.80
Brenham State School	\$164.12	\$20.44	\$72.72	\$19.58	\$32.16	\$309.03
Corpus Christi State School	\$156.33	\$45.31	\$69.85	\$17.97	\$31.81	\$321.27
Denton State School	\$163.97	\$45.94	\$65.26	\$17.98	\$32.96	\$326.11
San Antonio State School	\$174.35	\$36.11	\$70.73	\$19.08	\$28.94	\$329.20
El Paso State Center	\$161.45	\$33.48	\$82.03	\$18.38	\$34.01	\$329.35
Austin State School	\$179.55	\$30.38	\$72.13	\$18.92	\$33.97	\$334.95
Abilene State School	\$161.76	\$61.81	\$66.78	\$17.30	\$36.57	\$344.23
Richmond State School	\$182.59	\$42.93	\$70.48	\$17.85	\$42.98	\$356.83
San Angelo State School	\$181.86	\$32.22	\$87.00	\$18.91	\$47.36	\$367.35
Mexia State School	\$197.50	\$35.64	\$82.63	\$15.95	\$44.50	\$376.21
Lubbock State School	\$208.28	\$68.55	\$84.69	\$17.44	\$35.83	\$414.79
Rio Grande State Center	\$178.04	\$103.30	\$93.83	\$15.78	\$54.49	\$445.43
<b>STATEWIDE AVERAGE COST PER DAY</b>	<b>\$173.71</b>	<b>\$42.46</b>	<b>\$73.07</b>	<b>\$17.99</b>	<b>\$36.40</b>	<b>\$343.62</b>

Source: Legislative Budget Board

## Appendix D

### Breakdown of State Supported Living Centers and State Centers

SSLC	Open	Acres	Clients	Staff Positions	Staff Positions Filled	% of Positions Filled	Counties Served
Abilene	1957	302	454	1,542.31	1,463	94.86%	18
Austin	1917	93	377	1,219.38	1,216.78	99.79%	28
Brenham	1974	200	340	1,105.61	1,045.50	94.56%	10
Corpus Christi	1970	104	292	1,004.70	986.20	98.16%	21
Denton	1960	188	545	1,795.70	1,715.30	95.52%	18
El Paso	1974	20	136	447.80	445.25	99.43%	1
Lubbock	1969	226	230	951.56	897.86	94.36%	54
Lufkin	1962	159	405	1,190.66	1,153	96.84%	28
Mexia	1946	215	417	1,678	1,611	96.01%	12
Richmond	1968	842	407	1,447.75	1,388.75	95.92%	13
Rio Grande State Center	1956	78	72	258.50	223.25	86.36%	3
San Angelo	1969	1,031	251	861.20	813.70	94.48%	38
San Antonio	1978	43	281	822.45	798.15	97.05%	10

Source: State Supported Living Centers data as of August 28, 2010<sup>74</sup>  
 State Center data as of August 31, 2010

## Appendix E

### Breakdown of SSLC Residents

SSLC	Total	Average Age	Dual Diagnosis	% LON 1	% LON 5	% LON 8	% LON 6	% LON 9
Abilene	454	48	58%	5.5%	28.9%	38.1	24.4%	2.6%
Austin	377	51	60%	2.7%	32.4%	42.4%	22.5%	0.0%
Brenham	340	45	64%	2.6%	47.9%	35.3%	13.2%	0.6%
Corpus Christi	292	47	61%	4.5%	36%	32.2%	27.4%	0.0%
Denton	545	51	55%	2.4%	34.3%	37.4%	25.3%	0.0%
El Paso	136	44	65%	1.5%	39.7%	45.6%	11.8%	0.0%
Lubbock	230	46	60%	3.9%	36.1%	31.7%	27.8%	0.0%
Lufkin	405	47	53%	3.7%	43%	35.6%	16.8%	0.0%
Mexia	417	40	84%	18.9%	49.2%	22.1%	5.8%	0.0%
Richmond	407	49	48%	4.9%	38.3%	34.2%	21.9%	0.7%
Rio Grande	72	46	82%	4.2%	54.2%	34.7%	4.2%	0.0%
San Angelo	251	45	81%	11.2%	49.4%	28.3%	10.0%	0.4%
San Antonio	281	46	74%	3.6%	33.5%	34.5%	27.8%	0.0%

Source: DADS, data as of August 31, 2010

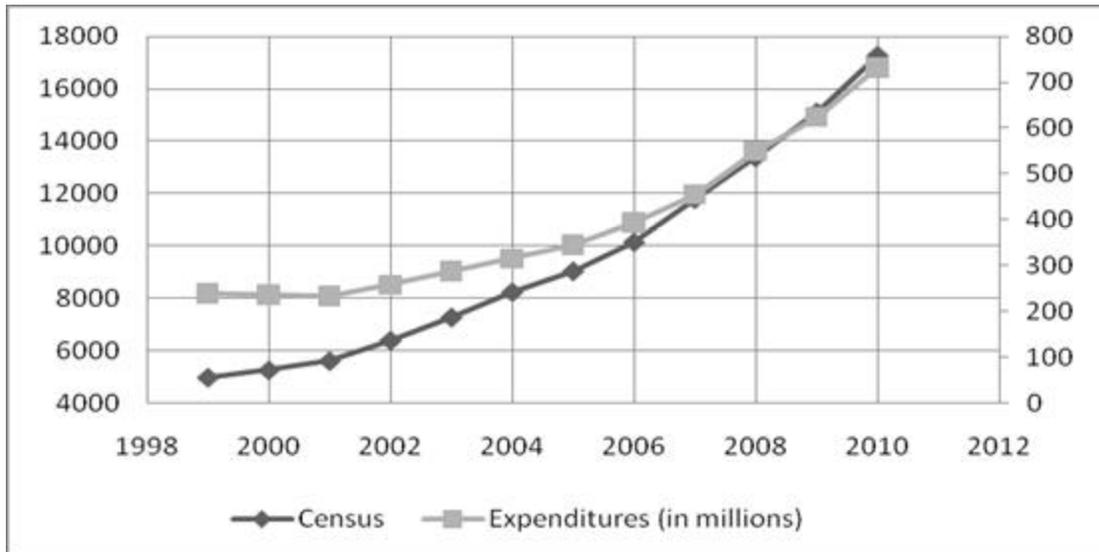
Note: Dual Diagnosis means an individual also has a psychiatric diagnosis

- LON 1: Individuals require limited personal assistance.
- LON 5: Individuals require anywhere from close supervision and guidance to direct assistance in accomplishing personal care.
- LON 8: Individuals require direct physical assistance/constant supervision.
- LON 6: Individuals have severe to profound deficits in intellectual functioning and the presence of maladaptive behaviors. Requires one-on-one supervision (less than 16 hours/day).
- LON 9: Individuals require constant, one-to-one supervision. Individuals assigned this level of need represent less than one percent of the individuals with an intellectual disability.

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## Appendix F

### Home and Community Services Census and Appropriations, FY 1999 to 2010



Source: Department of Aging and Disability Services

## CHARGE 2

*Monitor the implementation of provisions in SB 2080 (81R) relating to the creation of a permanency assistance program. Evaluate and make recommendations about the foster care licensing process for relatives, the payment structure for a relative who becomes a child's permanent managing conservator, and any factors that should be considered in evaluating program performance and sustainability in the future.*

### EXECUTIVE SUMMARY

Charge 2 focuses on Permanency Care Assistance (PCA), a new program created by SB 2080 (81 R). SB 2080 directs Texas Child Protective Services (CPS) to provide monthly assistance payments to relatives who sign an agreement to take legal custody of a relative foster child after 6 months of providing foster care. The program was adopted with several goals in mind, including:

- Attracting more relatives to guardianship who would like care for a child, but cannot afford to do so;
- Moving children out of impermanent foster care arrangements and into permanent relative care when possible;
- Preserving the child's extended family supports, promoting permanency and continuity in a child's living arrangement, and reducing multiple placements, keeping child safety as the primary goal;
- Avoiding costs of CPS case management and court hearings required as long as a child remains in foster care; and

This charge presents the PCA program, its history, and its role in Texas child welfare system. It describes how CPS and its partners are implementing the PCA program.

One major finding that emerged from this Committee's interim work is that as of October 1, 2010, only *one* CPS youth was enrolled in a PCA-supported guardianship agreement. The Committee feels that low early enrollment reports suggest a need for more ongoing monitoring and more effective agency recruitment practices.

### BACKGROUND: THE CHILD ABUSE AND NEGLECT CASE

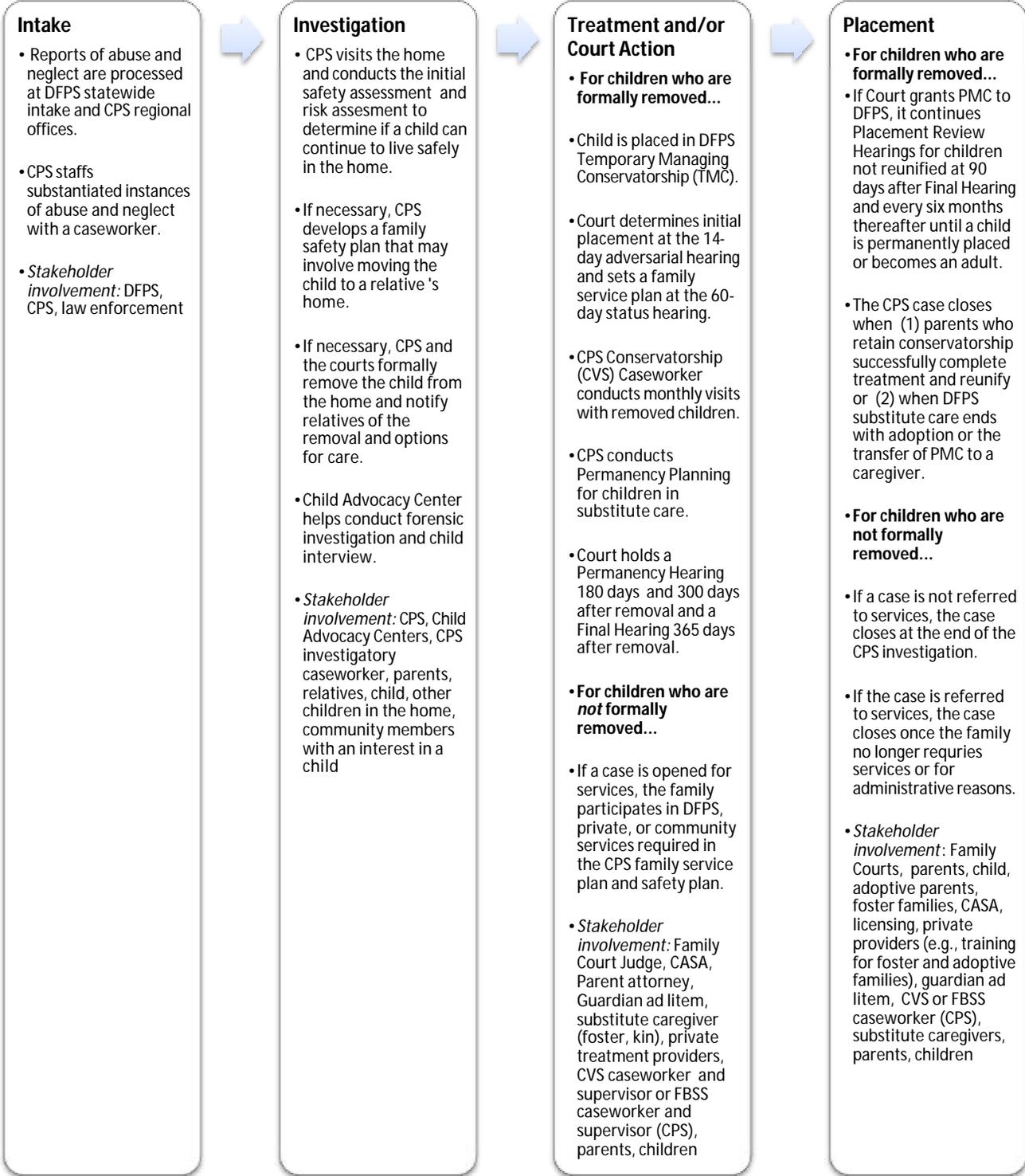
The child abuse and neglect case includes four major stages - intake, investigation, treatment and/or court action, and placement - and each stage incorporates a number of different stakeholders. The entity with the most enduring presence in a child abuse and neglect case is

the Child Protective Services (CPS) division of the Texas Department of Family and Protective Services (DFPS). DFPS is the first responder to a report of abuse and neglect at its state-wide intake center. If a child is found to be a victim of abuse and neglect, DFPS refers the case to a regional CPS office, assigns a case manager to each child victim, and monitors the progress of children and families through family services and/or court hearings until safety and permanence is attained for the child and the case is closed.

Figure 1 illustrates the four major stages of the child abuse and neglect case, major milestones for children and their families in each stage, and examples of stakeholder groups that may intervene.

At the **Intake** stage, the DFPS state-wide intake center in Austin, TX receives all allegations of child abuse and neglect and creates a report gathering as much information as possible from the caller. Reports are screened and referred to a regional CPS office. If the statutory definition of abuse or neglect is met, CPS will assign a report to an investigatory caseworker with a priority level. Priority 1 is assigned to high-risk cases and must begin investigation within 24 hours of the report. Priority 2 case investigations must begin within 72 hours.

Figure 1. The Child Abuse and Neglect Case



During the **Investigation** stage, the CPS caseworker collects additional information to determine if the child is safe, if abuse or neglect has occurred, if the child is at risk of future abuse or neglect, and if the child and family require services. The investigation begins when the CPS worker establishes first contact with a victim, a protective caregiver, or other relevant adult. It continues with interviews and examinations of the child victim and other children in the home; interviews with parents, caregivers, relatives, and others; criminal background and child abuse and neglect background checks of principals involved in the case; and a home visitation. The CPS worker uses this information to conduct a safety assessment and risk assessment of the child's home, and the findings of these assessments determine the level of state intervention.

During the Investigation stage, a child may be removed by court order due to safety concerns. When a child is removed, CPS is required to notify close relatives of the removal and their options for caring for a child within 30 days and to file a Family Service Plan for the child and family within 45 days. The **Family Service Plan** outlines the steps and services the child and family should follow through the CPS case. As part of a Family Service Plan, a family may be asked to participate in CPS Family Based Safety Services (FBSS), community services, or other private contracted services. Throughout this process, CPS conducts monthly home visits to monitor safety and risk while establishing priorities and planning for a child's permanent home. If a child has not been formally removed from home by court order, CPS remains involved only if the family is referred to FBSS or if additional safety and risk factors emerge requiring a formal removal.

According to state law, removing a child from a home should be a last resort to achieve safety and reduce risk in child abuse and neglect cases. CPS can take a variety of alternate actions during the **Treatment** stage to ensure child safety while avoiding removal. For example, CPS may choose to refer the family to CPS or community treatment services instead of seeking removal. In this case, CPS would work with the family to establish a written safety plan that outlines the actions that parents, relatives, and children must complete to ensure child safety. If CPS determines that (1) a child cannot be protected from imminent and serious harm in the home or (2) there are risk factors for future abuse and/or neglect that cannot be managed in the home, CPS may petition the court for an order to remove the child. If a removal occurs, DFPS takes Temporary Managing Conservatorship (TMC) of the child, places the child in substitute care, and staffs the case with a CPS conservatorship caseworker. As long as DFPS retains managing conservatorship and the child remains in substitute care, the CPS case will proceed through a series of **Court Hearings**, including:

- **The Adversarial Hearing** - held within 14 days of a child's removal to determine the initial placement of a child (either at home, with a relative or other designated

caregiver, or in foster care), to appoint parent counsel, and to grant DFPS Temporary Managing Conservatorship (TMC) of a child.

- **The Status Hearing** - held within 60 days of a child's removal to review a child's placement status and discuss the Family Service Plan.
- **The Permanency Hearing(s)** - held within 180 days of removal to monitor a family's compliance with the Family Service Plan and to establish permanency and concurrent goals. If family progress is insufficient, additional hearings may occur at 300 days and 420 days after removal to monitor child and family progress and to plan permanency.
- **The Final Hearing** - held within 365 days of removal to determine conservatorship and parental rights.

At the Final Hearing for children removed and placed in substitute care, the court decides whether to reunify the family, to extend treatment for up to 6 months, or to terminate parental rights and grant Permanent Managing Conservatorship (PMC) to DFPS. If the court reunifies the family at the Final Hearing or after a 6-month extension, the case is closed if the reunification is successful after a 6-month monitoring period. Children placed in the PMC of DFPS by the court either at the Final Hearing or after the 6-month extension enter the next stage in a child abuse and neglect case.

The final stage in the child abuse and neglect case - **Placement** - involves regular court placement hearings and continued CPS conservatorship caseworker involvement to monitor a child's living arrangements and to prepare a permanent home. During this time, CPS and the courts work toward the goal of the child's permanency plan.

If at any point in time during the **Placement Review Hearings** the child is reunified, adopted, or if the court transfers PMC to a caregiver, and if that placement is successful after six months, DFPS closes the case and refers families to other services. If none of these arrangements is possible or if a placement in one of these arrangements is ultimately unsuccessful, the child remains in (returns to) the PMC of DFPS and is placed in a foster home or foster group home. If the child has special needs, he/she may be placed in a residential treatment facility or state-supported living center. As long as DFPS retains PMC, the CPS case must remain open, and a placement review hearing is held every six months.

## PERMANENCY

### WHAT IS PERMANENCY?

Permanency is finding a safe and enduring home for a child victim of abuse and neglect. It became one of the top goals in the American child welfare system through the passage of the Adoption Assistance and Child Welfare Act of 1980 (Berrick, 1998). Before this Act, the child welfare system's focus on protection only left many children in long-term foster care with no

plans for a permanent home (Child Welfare Information Gateway, 2010(a)). The 1980 law addressed the prevalence of long-term foster care in state welfare systems by requiring state agencies and courts to:

- Make "reasonable efforts" to prevent removal of the child from the home and return those who have been removed as soon as possible;
- To provide adoption assistance payments to parents who adopt a welfare-eligible child who has special needs (e.g., cannot return home, cannot be placed without assistance).
- To establish reunification and preventive programs for children in foster care;
- To place the child in the least restrictive setting and close to home;
- To determine a child's future living arrangement in a timely fashion, within 18 months of removal; and
- To review placements of children in impermanent arrangements every six months.

Over the three decades that followed, changes in laws at the federal and state levels began emphasizing finding homes for child victims of abuse and neglect that "offer commitment and continuity," "have legal status," and "have members that share a common future" (Child Welfare Information Gateway, 2010(b)).

Today, permanency is a key consideration in federal and state child welfare policy discussions. The federal government, through the Child and Family Services Reviews (CFSRs), uses permanency outcome indicators - along with indicators of child safety and child and family well-being - to measure state child welfare system performance and compliance with federal law.

#### PERMANENCY PLANNING IN A CPS CASE

Permanency is a concern for all children that must be removed from the home and placed in substitute care for safety and risk reasons. Permanency planning begins with CPS's family-finding efforts at the time a child is removed from the home and continues with CPS's development of Family Service Plan, the 60-day Status Hearing, the 180-day Permanency Hearing, the 365-day Final Hearing, and subsequent Placement Review Hearings.

Permanent living plans for children placed in substitute care begin to solidify with the development of a **Family Service Plan**. Part of the Family Service Plan involves setting a permanency goal and concurrent goal (SB 939, 81R) for a child. To formulate its permanency goal recommendation, CPS reviews and assesses the child's needs revealed through investigations, safety and risk assessments, and the Family Safety Plan. CPS considers the child's best interest, existing relationships, and the child's needs for safety, permanency, wellbeing, and an enduring and nurturing family relationship.

The process of selecting a **permanency goal** also incorporates a **permanency priority** list that places family preservation at the highest priority level, followed by family reunification as the second priority, an alternative placement with a long-term commitment (e.g., adoption, kinship guardianship) as the third priority, and another planned living arrangement (e.g., preparation for independent living) as the fourth priority (CPS Handbook §6221.1). These priorities are founded in federal and state child protection law (Texas Family Code 263.301-307). In order to select a lower-level priority as a goal, state law requires that every priority that lies above that option in the priority list must first be ruled out.

The court may eliminate reunification as a permanency priority option in "aggravated circumstances," for example, when a parent inflicts or allows another to inflict serious bodily harm to a child, commits a criminal offense against a child, or leaves a child with another caregiver for six months without expressing an intent to return or to support the child (Texas Family Code §262.2015). When the court rules family reunification out due to aggravated circumstances, the CPS caseworker must begin permanency planning with the next-highest priority, which is alternative family placement with a long-term commitment. Table 1 lists the permanency priorities, examples of the living arrangements associated with each priority, and the criteria CPS uses to select that priority.

**Table 1. Texas Child Protective Services Permanency Priorities**

Permanency Priority	Living/Care Arrangement	CPS Selection Criteria
Family Preservation	Home	<ol style="list-style-type: none"> <li>1. Child has <i>not</i> been removed.</li> <li>2. Family is willing and able to reduce risk and child can live at home safely in the future.</li> </ol>
Family Reunification	Home	<ol style="list-style-type: none"> <li>1. Child has been removed.</li> <li>2. Family is willing and able to reduce risk and child can live at home safely in the future.</li> </ol>
Alternative Family Placement with a Long-Term Commitment*	Relative adoption Relative PMC Non-relative adoption Non-relative PMC Foster care w/ DFPS PMC ** Other care w/ DFPS PMC **	<ol style="list-style-type: none"> <li>1. Child has been removed.</li> <li>2. Parents are <i>unwilling or unable</i> to reduce the risk of abuse or neglect enough for child to return home safely.</li> </ol>
Another Planned Living Arrangement	Preparation for independent living Preparation for adult living with community assistance	<ol style="list-style-type: none"> <li>1. Child has been removed.</li> <li>2. Parents are unwilling or unable to reduce the risk of abuse or neglect enough for the child to return home safely.</li> <li>3. Youth is at least 16 years old (18 with developmental disability).</li> <li>4. Youth is not able to function in a family setting due to treatment needs or family cannot provide a</li> </ol>

		long-term relationship. 5. Youth's best interests and long-term needs are best met with this option.
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\* Alternative family placement options are listed in preferred order. Relative adoption or conservatorship is preferred to non-relative adoption or conservatorship and adoption is generally preferred to PMC.

\*\* CPS caseworkers cannot select a permanency goal that involves DFPS retaining PMC unless the higher ranking goals have been ruled out and the worker can document a compelling justification for the goal. Goals involving DFPS as PMC, if selected, must be reassessed with each review of the Service Plan.

Source: CPS Manual §6221.1, 5221.41.

After the permanency goal and concurrent goal are selected, CPS must add to the Family Service Plan the specific steps that parents, relatives, children, and child caretakers have agreed to take to achieve and support the child’s permanency goal.

To facilitate the permanency planning process, CPS applies the **Family Group Decision Making (FGDM)** philosophy, which encourages family participation and voice in permanency decisions. CPS uses a number of different FGDM models: Family Group Conferences, Circles of Support, and Transition Plan Meetings. The type of planning meeting selected for a child in substitute care depends on the age and needs of the child and the family, and planning meetings are generally subject to timelines in the CPS abuse and neglect case (CPS Manual §6437.3).

In general, the FGDM approach invites the child, parents, caregivers, relevant community members, CASA, CPS caseworkers and supervisors, and relevant child specialists to a meeting facilitated by a trained FGDM specialist to finalize the Family Service Plan. The FGDM facilitator coordinates group discussion of the child abuse and neglect concerns that prompted the conference; goals, hopes and dreams for the child(ren); family strengths and supports; and tasks and services required of parents, children, and caregivers in the future. The information is included in the Family Service Plan document, which is signed by the meetings' participants.

Once it is completed, CPS must file the Family Service Plan with the court, and this filing must take place within 45 days of a child’s removal. The permanency plan may be reassessed and revised, if necessary, before it is presented and discussed in court at the first **Permanency Hearing** within 180 days of the child’s removal. At the Permanency Hearing(s), the court will review CPS's permanency plan, establish a permanency and concurrent goal, and set a date for the **Final Hearing** to decide parental rights and conservatorship regarding a child. The ultimate decision regarding child permanency rests with the court at the Final Hearing or, if DFPS is appointed PMC at the Final Hearing, at subsequent Placement Review Hearings. This court decision is informed by the testimony of children, parents, attorneys ad litem, guardians ad litem (CASA), parent attorneys, caregivers, caregivers attorneys, and CPS.

## PERMANENCY CHALLENGES IN TEXAS

Texas continues to struggle to meet federal standards for child permanency. State compliance with these standards is monitored by the U.S. Children's Bureau's through its Child and Family Services Reviews (CFSRs). Texas' last evaluation was part of the CFSR Round 2 in 2008.

#### CHILD AND FAMILY SAFETY REVIEW – ROUND 2

CFSR reports evaluations in three areas: national standards, outcomes, and systemic factors. State performance is tested against six national standards and evaluated based on substantial conformity, defined as compliance in 95 percent of cases, on seven outcomes and six systemic factors.

The CFSR reports whether state measures meet or exceed six national standards set forth by the CFSR. The six national standards are:

- absence of maltreatment recurrence,
- absence of child abuse and/or neglect in foster care,
- timeliness and permanency of reunifications,
- timeliness of adoptions,
- permanency for children and youth in foster care for long periods of time,
- and placement stability.

In its Round 2 Texas met *one of the six* CFSR national standards, absence of maltreatment recurrence.

The seven outcomes are grouped into three areas: Safety, Permanency, and Child and Family Wellbeing. They are outlined below.

- Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.
- Safety Outcome 2: Children are safety maintained in their homes whenever possible and appropriate.
- Permanency Outcome 1: Children have permanency and stability in their living situations.
- Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.
- Child and Family Wellbeing Outcome 1: Families have enhanced capacity to provide for their children's needs.
- Child and Family Wellbeing Outcome 2: Children receive appropriate services to meet their educational needs.

In Round 2, Texas achieved substantial conformity with *one of the seven CFSR outcomes*, Child and Family Wellbeing Outcome 2: Children receive appropriate services to meet their educational needs.

The seven systemic factors are:

- statewide information system
- case review system, quality assurance system
- staff and provider training
- service array and resource development
- agency responsiveness to the community,
- and foster and adoptive parent licensing, recruitment, and retention.

In Round 2, Texas achieved substantial conformity with *five of the seven* systemic factors. It did not achieve substantial conformity in the areas of case review system and service array and resource development.

TEXAS’ PROGRAM IMPROVEMENT PLAN

After the Round 2 CFSR results for Texas were published, Texas was given an opportunity to respond through a Program Improvement Plan (PIP), which was submitted to the U.S. Children’s Bureau on April 1, 2010.

In the PIP, Texas explains how it has diverted many children from DFPS PMC to kinship placements since 2000 in an attempt to improve permanency. Kinship care in Texas has served young, low-needs children best. Table 2, taken from the Program Improvement Plan, shows that *78 percent of all children successfully placed with kin in Texas are under age 9*. Those left in CPS substitute care (DFPS PMC) tend to be older youth with more specialized needs. Table 2 also shows that the share of special needs children successfully placed in kinship homes is lower than the share of special needs children in CPS substitute care for each special needs category except drug/alcohol.

**Table 2. Age and Special Need Composition of Children in Kinship Care versus General CPS Substitute Care, August 2008\***

	Percent of All Children in Kinship Placements	Percent of All Children in CPS Substitute Care
<b>Age</b>		
0-2	33	25
3-5	24	18
6-9	21	19
10-13	13	17

14-17	9	21
<b>Special Needs</b>		
Physical	0.4	1
Mental	3	7
Drug/Alcohol	11	11
Emotional	7	22

\* Numbers have been rounded to the nearest decimal point unless <1.  
Some children may have more than one special need.

## IMPROVING PERMANENCY OUTCOMES IN A COMPLEX SYSTEM

Improving permanency requires a joint effort among the many stakeholders involved in a child welfare intervention. The system is complex, and many decisions during the life of a CPS case may affect whether legal permanence is achieved in a timely fashion.

The state of Texas believes that the PCA program will play an important role in removing barriers to permanency by creating new, safe, permanent homes for foster children with relative guardians.

## THE PERMANENCY CARE ASSISTANCE PROGRAM

### FEDERAL FOSTERING CONNECTIONS TO SUCCESS AND INCREASING ADOPTIONS ACT

In 2008, Congress passed the Federal Fostering Connections to Success and Increasing Adoptions Act (hereafter, "Fostering Connections"). The purpose of Fostering Connections was to provide new funding to connect relatives with children in state care as a result of abuse and/or neglect, to improve outcomes for children, and to enhance adoption incentives.

Fostering Connections required the states to notify all adult relatives of children within 30 days of a child's removal and their options to become a placement resource, to make "reasonable efforts" to place siblings together, to coordinate health care services for foster children, and to develop a case plan for ensuring educational stability for foster children (Child Welfare information Gateway, 2009). It also created an option for the states to provide kinship guardianship assistance payments under Title IV-E funding to families who sign a written agreement to take legal custody of a relative foster child; an option to extend monthly adoption or guardianship assistance past age 16 for some children who exited foster care at age 16; and an option to extend foster transition services and education vouchers to children who exited foster care to adoption or guardianship assistance programs after age 16.

This charge focuses on Fostering Connections' creation of a new Title IV-E funding stream for states to develop kinship guardianship assistance programs. This incentive encouraged Texas and other states to create or expand their own guardianship assistance programs as part of a

federal-state partnership to attract more relatives to care. Before describing Texas' program in detail, we will explain the role envisioned for guardianship assistance programs in the states.

#### THE REASON FOR STATE GUARDIANSHIP ASSISTANCE PROGRAMS

Studies have shown that in Texas and elsewhere, financial barriers prevent more relatives from caring for child abuse and neglect victims. The purpose of state guardianship assistance programs is to provide the resources these relatives need to create safe and enduring family homes as legal guardians for children who might otherwise remain in foster care.

Why would the states want to recruit more relatives to care? Beyond the nation's more general focus on family-centered interventions, an emerging body of research suggests that encouraging more relative care may child outcomes in the child welfare system. The research suggests that placements with relative caregivers can preserve safety, offer more stability, reduce trauma, preserve family ties, and promote child development in a family culture (Koh, 2009; Cuddebackm 2004; Berrick, 1998).

However, the same body of research raises important concerns about adequate resources for kinship caregiving. Research finds that relative caregivers are more likely than other caregivers to be single, elderly, economically disadvantaged, caring for multiple dependents, and to have less knowledge of or access to available services (Koh, 2009; Simpson and Lawrence-Webb, 2007; Cuddeback, 2004; Goodman et. al, 2004).

#### EARLY SUPPORT FOR KINSHIP CAREGIVING IN TEXAS

Before Fostering Connections, kin in Texas who agreed to provide long-term care for a child would only be eligible to receive regular, monthly cash assistance and services if they became adoptive parents or foster parents. Senate Bill 6 (79R) provided a new alternative and incentive for kinship care by offering limited support to relatives or other designated caregivers who agreed to provide a home for children in the conservatorship of DFPS.

The Relative and Other Designated Caregiver program offered a reimbursement of up to \$1,000 in one-time integration funding for child-related expenses. Families who eventually took legal custody of the child were eligible for reimbursements up to \$500 per year per child for a maximum of 3 years. Training and case management services, supportive family counseling services not covered by Medicaid, daycare services to qualified children and kinship care giving families, and referral/coordination to determine eligibility for additional public assistance are also available through the Relative and Other Designated Caregiver Program.

A concerted effort to attract relatives and fictive kin to care, along with these new financial incentives for families, resulted in substantial growth in kinship care. The *DFPS Progress Report: Relative and Other Designated Caregiver Assistance Program* (2009) finds that from

2000-2008, Texas has more than *doubled* the percentage of children and youth in its care who are placed with kin. This trend continues. In FY2008, the Relative and Other Designated Caregiver Program supported 4,299 families containing 7,755 children. In FY2009, the number had grown to 4,833 families containing 8,481 children.

According to DFPS (2009), kinship care has benefitted Texas in a number of ways. First, it has helped to improve the stability of children's living arrangements while in DFPS care. Experiencing a kinship placement impacts how quickly children and youth exit from CPS care. Those who have had a kinship placement exit more quickly than those children who have not, and they are more likely to exit to a kin placement. Children and youth initially placed with kinship caregivers are less likely to experience multiple placements. Also, children and youth in Texas who are living in a kinship placement are less likely to re-enter substitute care. DFPS does not have information on whether the quality of care and/or child wellbeing differs in kin versus non-kin foster homes.

However, even with the support of the Relative and Other Designated Caregiver Program, Texas and other states continue to struggle with building new permanent home options for CPS children among kin. There remains a significant shortage of adoptive and guardian home capacity, making it difficult to find legal permanence for the children who remain in the PMC of DFPS.

#### RECRUITING KIN TO PERMANENT CARE: EXPERIMENTATION WITH GUARDIANSHIP ASSISTANCE IN THE STATES

In an effort to build more permanent care options with kin, several states began experimenting with guardianship assistance programs. These programs introduced monthly assistance payments to kin on behalf of children in exchange for kin commitment to become legal guardian for a child in foster care. Title IV-E waiver funding for these demonstration projects was made available through the 1997 Adoption and Safe Families Act.

As a condition of the waiver, states were required to conduct program evaluations. Results from these evaluations suggest that while guardianship assistance effects varied widely among the states, most appeared to promote permanency and reduce the duration of state care. In Montana, child wellbeing improved in the areas of school performance, risky behavior, and access to community resources. In Minnesota, children supported by guardianship assistance programs showed improved emotional wellness, improved caregiver-child relationships, and stronger overall wellbeing. These studies provide less evidence that guardianship assistance reduced the recurrence of child maltreatment or reduced the incidence of foster care re-entry. This may be because these incidents were very rare to begin with in the evaluation states. A summary of the state demonstration evaluation studies is available at the U.S. Children's

Bureau

website:

[http://www.acf.hhs.gov/programs/cb/programs\\_fund/cwwaiver/2010/summary\\_demo2010.htm](http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/2010/summary_demo2010.htm).

#### SENATE BILL 2080: GUARDIANSHIP ASSISTANCE IN TEXAS

The federal Fostering Connections law (P.L. 110-531) set forth several baseline requirements for all state guardianship assistance programs. These requirements established the framework for Texas' PCA program:

1. To be eligible to apply for kinship guardianship assistance, the relative must become a foster parent, and a child must be cared for by those relative foster parents for six consecutive months prior to enrollment.
2. States must enter into a binding, written agreement for guardianship assistance with relatives that specifies the amount and manner in which the assistance payment will be made, the manner in which payments may be adjusted over time, additional services and assistance available to the guardian and child under the agreement and how to apply, and that the agency will pay the cost of nonrecurring expenses related to obtaining legal guardianship of the child up to \$2,000.
3. The monthly guardianship assistance payment amount cannot exceed foster care maintenance payments.
4. Guardianship assistance payments cannot begin until the guardianship assistance agreement is signed *and* the relative has established legal guardianship;
5. The state child welfare agency must determine that returning home or adoption is not a permanent option for the child, that the child has a strong attachment to relative, and that the relative has a strong commitment to the child.
6. Relatives and other adults in the guardianship assistance home must submit to fingerprint criminal background checks and child abuse and neglect registry checks;
7. Relatives must first become licensed as foster homes for the child, and states are permitted to waive "non-safety" licensing standards on a case-by-case basis for relative foster homes;
8. For each child for whom relative guardianship with the support of guardianship assistance is the permanency plan, the following must be documented in the case plan: (1) how the child meets eligibility requirements, (2) the steps the agency has taken to rule out reunification or adoption, (3) efforts agency has taken to discuss adoption with foster parents and reasons this adoption is ruled out, (4) efforts agency has made to discuss kinship guardianship with child's parents and/or why efforts were not made, (5) reasons why kinship guardianship with assistance is in the

child's best interest, and (6) efforts agency has made to discuss a child's kinship guardianship arrangements with the child's parents and/or why efforts were not made.

9. Medicaid is available and eligibility will be evaluated for children supported by guardianship assistance when regular payments of any kind (i.e., foster or guardianship assistance) begin (DHHS, July 9, 2010);
10. Payments must stop if an agency determines that the relative guardian is no longer legally responsible for a child, if the child is no longer receiving support from the guardian, or if the child attains age 18 (or older, if eligibility is extended to age 19, 20, or 21 by state law). Relative guardians are required to notify the child welfare agency of these or any circumstances that would terminate a child's eligibility.

DHHS allowed the states to define "relative" for eligibility purposes (DHHS, July 10, 2010) and to extend kinship guardianship assistance payments on behalf of children who enter into agreements after age 16 up to age 19, 20, or 21 if the child completes high school or its equivalent, is enrolled in post-secondary or vocational school, is in a program to eliminate barriers to employment, is employed 80 hours a month, or in is incapable of these things due to a medical condition (DHHS, February 10, 2010).

Texas Senate Bill 2080 (81R) offered an additional level of policy specification that distinguishes guardianship assistance in Texas:

- Defines "relative" for eligibility purposes as a person related to a foster child by consanguinity or affinity;
- Allows PCA eligibility extensions until age 21 for children and caregivers who sign a permanency care assistance agreement after the child's 16th birthday, if the child meets certain eligibility criteria;
- Charges the executive commissioner of the Texas Health and Human Services Commission with developing eligibility policy and ensuring Texas rules conform to Fostering Connections requirements;
- Authorizes signed agreements starting September 1, 2010 and payments starting October 1, 2010;
- Sunsets the program on August 31, 2017.

## OVERVIEW OF THE PCA PROGRAM

The program rules established by DFPS, at the request of the 81st Legislature, can be found in the Texas Administrative Code §700.1025 - §700.1057 and the CPS Manual §1580 and §6322.5 – 6322.7. This section summarizes state law and agency policy related to Permanency Care Assistance.

## RECRUITMENT

According to DFPS, informing relatives about the PCA program will become a part of all CPS cases that involve a removal. This is due to existing laws at the federal and state level requiring DFPS to make "reasonable efforts" to locate relatives within 30 days of removal. Policy addressing the recruitment of relatives to care can be found in the CPS Handbook (§2262.3, 2663, 6133, and 6134.4).

CPS has reported that it has made a special effort to target two groups of children for the PCA program: (1) those in DFPS PMC already living with relatives or fictive kin and (2) those in the conservatorship of DFPS without termination of parental rights (DFPS, July 17).

## ENROLLMENT

Prospective guardians can apply to the PCA program through the CPS Foster to Adopt (FAD) program or through a private child placement agency contracted by DFPS. To enroll, the prospective guardian must complete a number of steps.

1. The guardian must apply for a foster care license, which requires fingerprint background checks of home members, the completion of an approved home study by Residential Child Care Licensing (RCCL), meeting the minimum standards of RCCL, and entering into a **Foster Care Placement** Authorization Agreement.
2. As a foster parent, the prospective guardian must sign a **Statement of Intent** to pursue PMC of the child with the support of PCA payments.
3. Once the relative foster parent has cared for the child for six consecutive months, CPS will assist the relative in completing a **PCA Application**. To ensure eligibility, the relative must complete the application 30 days before being granted PMC in court. DFPS must notify the relative of whether or not child benefits applied for have been approved before the court grants PMC.
4. If the application is approved, the CPS caseworker works with the relative to negotiate a written **PCA Agreement** that establishes the monthly payment amount, method of payment, and other details.

5. The relative must be granted PMC in court to begin receiving assistance payments or reimbursements on behalf of the child. CPS policy requires PCA payments to begin the first day of the first month after the court transfers PMC to the new guardian.

#### FOSTER CARE LICENSING FOR RELATIVES

DFPS has not created a separate licensing process for kin planning to transition from foster parenting to guardianship supported by PCA payments. Because Fostering Connections neither superseded nor rescinded existing state licensing law, the agency will continue to apply the same minimum standards to prospective kin foster parents and prospective non-kin foster parents. DFPS's goal is to verify families that remain engaged in the licensing process within 120 days of the initial application. RCCL expects to handle special kin foster care licensing issues by variance requests, which give applicant families the opportunity to comply with minimum standards in a different way or to nearly comply with a standard in special circumstances.

#### TRAINING FOR PCA CAREGIVERS

Training for prospective PCA guardians is provided through the foster care mini-PRIDE or PRIDE curriculum.

#### PAYMENTS

Children enrolled in the PCA program are eligible to receive up to \$2,000 in reimbursements for costs of obtaining legal conservatorship of a child. Negotiated monthly assistance payments must be lower than foster care payments. For children at the basic service level, DFPS expects payments to range between \$400-545 per month per child. Actual payment rates are negotiated between the state and the kin guardian(s).

#### MONITORING DFPS PROGRAM IMPLEMENTATION EFFORTS

##### INTERNAL PREPARATION

DFPS prepared for the rollout of the PCA program through kickoff meetings, staff training, departmental memos, and CPS Handbook updates. CPS held a PCA implementation kick-off for managers on January 20, 2010. In the summer of 2010, CPS began issuing departmental memos to ensure staff was fully aware of the program.

CPS conducted Fostering Connections training between July 15, 2010 and December 1, 2010 for CPS caseworkers in the areas of Conservatorship, Adoption, I See You, Kinship, FGDM, Preparation for Adult Living, Foster Care Eligibility, Adoption Eligibility, Investigation, FBSS, and Foster-to-Adopt caseworkers. Training was offered via video, web-based PowerPoint

presentations, IMPACT demonstration, and/or classroom training. Staff were required to attend at least one training session and were asked to view the video as an introduction.

CPS added new PCA policy to the CPS Handbook in September 2010.

#### PARTNER OUTREACH

DFPS is sharing PCA program information with stakeholders via a series of presentations scheduled throughout 2010 with 7 stakeholder groups and informational letters to residential contractors and the judicial community.

#### ENROLLMENT

By October 1, 2010, one family had signed a PCA Agreement and began receiving payments on behalf of a child. DFPS had identified 130 children in kinship foster homes where the plan appears to be guardianship with the support of PCA payments. The state has not been tracking Statements of Intent (DFPS, October 16).

#### FEDERAL PROGRAM INSTRUCTION & TEXAS' RESPONSE

The U.S. Department of Health and Human Services released additional Program Instruction on February 18, 2010 and July 9, 2010 related to state questions on guardianship assistance eligibility, payments, and licensing. Texas CPS has addressed the following questions in its program design.

#### **Is federal reimbursement for guardianship assistance programs only available on behalf of new guardianships?**

DHHS instruction allowed state Title IV-E agencies "to convert legal guardianships that existed prior to the plan submission, including those that may have been supported through State or Tribal funds, to the title IV-E GAP program provided that those children meet all eligibility criteria..." (DHHS, February 18, 2010).

Texas does not plan to convert existing legal guardianships to guardianships supported by the PCA program. Texas PCA eligibility rules require PCA Agreements to be signed before the transfer of PMC to a kin guardian, a policy that bars legal guardianships existing prior to the enactment of Fostering Connections from enrolling in the PCA program. Under this policy, caregivers supported by payments through Texas' Relative and Other Designated Caregiver program and who have already obtained PMC in court prior to September 1, 2010 cannot leave that program and enroll in the PCA program.

#### **Will PCA children receive foster payments for first 6 months?**

DHHS instructs that payment of foster care benefits to PCA children is not required: "While the Act does not require Title IV-E foster care maintenance payments to have been paid on behalf of the child during the six-month timeframe, it does require that such a child meet all title IV-E foster care maintenance payment eligibility criteria... in the home of a fully-licensed or approved relative foster parent for a consecutive six-month period to be eligible..." (DHHS, February 18, 2010).

Texas *will* provide foster care payments to prospective PCA guardians for the first six months, in accordance with the state's interpretation of the Miller vs. Youakam decision (440 US 125 No. 77-742). In Miller vs. Youkam, the Supreme Court ruled 8-1 that it was improper for a state to deny relative caregivers verified as foster parents the same benefits as foster parents under the Aid for Families with Dependent Children Program.

#### CAN FOSTER CARE LICENSING REQUIREMENTS FOR RELATIVES BE MET BY VARIANCE REQUESTS?

Federal program instruction allows the states to determine what constitutes a non-safety licensing standard that can be waived for a prospective PCA foster home. It instructs that the reason for waiver and licensing approval should be documented as it relates to each relative child and that waivers should be applied equally (DHHS, July 9, 2010). DHHS will also extend Title IV-E reimbursement when a state licensing requirement is met by a variance request (DHHS, July 9, 2010).

Texas RCCL expects to handle most "non-safety requirements" via variance requests, as it does not categorize licensing standards as "safety" and "non-safety" and has not designated any "non-safety" requirements to be universally waived for prospective PCA homes (DFPS memo, July 15, 2010). RCCL will be collecting systematic information on the use of variance requests in its CLASS system. Changes rolled out on August 29, 2010 will provide the additional data elements needed to allow the agency to run reports on the application of variance requests by region.

#### **At what age should children be consulted as to whether they want a specific relative guardianship arrangement?**

DHHS instructs that children aged 14 or older should be consulted as to whether they want a specific relative guardianship arrangement to be their permanency plan (DHHS, Feb 18, 2010). Texas agency rules require that the CPS caseworker consult with youth aged 14 or older about the prospective guardian's interest before the PCA agreement is signed (§6322.7). When ruling out adoption, CPS must consider the child's wish to be or not to be adopted, if the child is age 12 or older (§6322.72)

## **Can guardianship assistance payments be received on behalf of siblings placed in the same home?**

States are allowed to provide guardianship assistance for siblings of eligible children and to define "sibling" (DHHS, February 10, 2010). Texas DFPS rules state that a PCA guardian who has previously entered into a PCA agreement on behalf of a child is also eligible to receive PCA payments on behalf of the child's siblings if: (1) the sibling lives in the same home, (2) the caregiver(s) and DFPS agree that the placement is appropriate, and (3) DFPS has TMC or PMC of the sibling when the PCA agreement is signed (§6322.76).

### **Other Instruction**

Additional DHHS program instruction gives states the ability to:

- Establish specific eligibility criteria, such as extending the time period a relative caregiver must serve as a foster parent beyond 6 months, targeting a certain age group for guardianship assistance, or requiring relative guardians to inform the agency of parental visitations or to cooperate in the enforcement of parental child support (DHHS, July 9, 2010).
- Evaluate, reevaluate, or terminate guardianship assistance agreements by specifying under what conditions a guardian is providing support to or has legal guardianship of a child, whether and when payments stop if a child reenters foster care, whether written agreements should be renewed periodically, and whether and how the extension requirements for education, employment, or disability are met, for example (DHHS, July 9, 2010).

## **EMERGING ISSUES**

### **ENROLLMENT**

Low early enrollment is noted in research findings. As of October 1, only one CPS youth was enrolled in a guardianship arrangement supported by PCA payments, but 130 have been targeted for potential enrollment. Although this data point may not be a pressing concern due to the early stage of the program's implementation, more frequent monitoring of enrollment is recommended during the 82nd Legislative Session.

### **TARGETING AND PROGRAM SUCCESS: CHILDREN AND CAREGIVERS**

Texas has not formally targeted the PCA program to specific child group. However, it is making special efforts to recruit youth (older children) in DFPS PMC placed with kinship families and youth in PMC without termination of parental rights (DFPS, July 15). State evidence suggests that many of these older children are difficult to place and have special needs.

While the PCA program’s monthly assistance payments may help to address relatives’ financial barriers, whether the program will provide an attractive level of support for caregivers requires further monitoring. Lessons from the Relative and Other Designated Caregiver program suggest that relatives can be attracted away from kinship care to foster care, because foster care offers more robust supports and training for the caregiver (DFPS, December 2009).

**KIN CHOICE OF CARE**

In Texas, kin have several choices for care when a child cannot return safely home. Federal and state law prioritizes adoption. If adoption is ruled out, kin guardianship is the next priority. Only if kin guardianship is ruled out must DFPS retain PMC of the child. If a child remains in DFPS PMC, kin may still care for children, but the state support arrangement would be channeled through the Relative or Other Designated Caregiver Program (for unverified kin homes) or through foster care (for verified kin homes). Each kin choice of care involves a different level of benefits and responsibilities, presented in Table 3.

**Table 3. Care Options for Relative and Fictive Kin in Texas: Benefits and Responsibilities**

	<b>Adoption</b>	<b>PCA</b>	<b>Kinship Care</b>	<b>Foster</b>
<b>BENEFITS</b>				
Recurring payment	Up to \$400-545/mo	Up to \$400-545/mo	\$0*	\$665/mo; Based on level of service need
One-time payment / reimbursement	Up to \$1,500	Up to \$2,000	\$1,000	n/a
Day care	No	No	If eligible, Yes	If eligible, Yes
Child Medicaid	Yes	Yes	Yes	Yes
Caregiver training	PRIDE	Mini-PRIDE or PRIDE	Adult Support Education Group (optional)	PRIDE
Eligibility ext. to age 21	Yes, if eligible	Yes, if eligible	No	Yes, if eligible
Education and training voucher	Yes	Yes	No	Yes, if aging out of care
<b>RESPONSIBILITIES</b>				
Background checks	DFPS/CPS and FBI	DFPS/CPS and FBI	DFPS/CPS and FBI if < 3 yrs resident	DFPS/CPS and FBI
Home requirements	RCCL home study & verification	RCCL home study & verification	CPS home assessment	RCCL home study & verification
CPS case remains open	No	No	Yes	Yes
Court case remains	No	No	Yes	Yes

open				
CPS face-to-face visits	No	No	Yes, at least monthly	Yes, at least monthly
Retain an attorney	Yes	Often	No	No
Caregiver legal status	Become parents	Become conservators	Optional conservators	DFPS is conservator
Income eligibility test for funding	No	No	Yes	No
Recertification or reevaluation of caregiver home	Every 5 years until age 18, annually after	Every 5 years until age 18, annually after	No	Verification is non-expiring; reevaluation every 2 years

\* \$500 per year for up to 3 years is available if relative or other designated caregiver obtains PMC.

Source: Department of Family and Protective Services, August 2010.

Adoption and PCA guardianship compare similarly in benefits and offer slightly different responsibilities. Adoptive kin must become parents, while PCA caregivers must become guardians. Adoptive parents must retain an attorney that is optional for PCA guardians.

DFPS feels that kin guardianship supported by PCA payments may be more appropriate than adoption in some instances. To ensure that PCA does not grow at the expense of adoptions, CPS has created more specific policy guidelines about the appropriate instances for ruling out adoption (§6322.72):

- When DFPS legal representatives and the CPS program director reach a decision that legal termination of parental rights is not achievable;
- When legal termination of parental rights is achieved, if permanency with a verified kin caregiver is in the child's best interest (considers the child's immediate and long-term safety; needs and well-being; wishes and wants; sibling relationships; social, educational, and mental health needs; and kin relationship, preferences, and ability); or
- The child is 12 years or older and does not want to be adopted.

Foster care and PCA guardianship differ noticeably in benefits and responsibilities. Foster care recurring payments are larger, but foster parents receive no one-time support, and foster parents are eligible for subsidized childcare and PCA guardians are not. Medicaid, eligibility extensions, and education and training voucher benefits are similar for the two arrangements. Both PCA guardians and foster parents must submit to DPS/CPS abuse and neglect checks and FBI criminal checks and complete a RCCL home study and verification. The key responsibility differences are related to CPS and court involvement. In PCA arrangements, CPS and court involvement ends; and in foster care arrangements, they continue, as DFPS remains managing conservator.

Although foster care may seem more appealing to some kin because of its benefits structure, under federal and state law, CPS should not allow a relative to become a foster parent unless guardianship has been ruled out of the permanency priority list.

This permanency priority process is complicated by the design of the PCA program, which requires prospective guardians to become verified foster homes for six consecutive months before transitioning to guardianship with or without PCA payments. If prospective guardians are not granted conservatorship by the courts, the child will not become eligible for PCA assistance. A prospective guardian who enters foster care anticipating PCA guardianship, but who cannot obtain conservatorship, may choose to remain caring for the child as a foster parent. Alternatively, the kin caregiver may drop out of system care entirely, resulting in another failed placement for the child. To ensure that prospective PCA guardians intend to make a long-term commitment to a child regardless of the ultimate legal status decision of the court, CPS policy urges caseworkers to explain to prospective guardians that DFPS' priority is to secure a long-term permanent home for the child on the first day of foster care (§6322.53).

This potential dilemma highlights the importance of coordinating CPS and court actions to ensure the ultimate success of state permanency efforts, including placing more children in kin guardian homes with the support of PCA payments.

#### EVALUATING PROGRAM SUCCESS

SB 2080 sunsets the PCA program on August 17, 2017. The sunset provision allows the state to evaluate the success of the program before it makes a decision whether to permanently integrate it into the Texas child welfare system.

The Committee recommends that DFPS consider a formal evaluation study. If a formal evaluation is not possible, the Committee recommends a DFPS report on performance. The Committee anticipates that the following metrics collected by CPS, RCCL, and DFPS will be useful in monitoring program success:

- **Permanency rate of PMC children:** Frequency of children who *exit* state PMC into permanent placements with adoptive parents, with guardians in the PCA program, with guardians in the Relative and Other Designated Caregiver program, and with other guardians.
- **Size of eligible group in DFPS PMC:** Frequency of children by age and duration of stay in DFPS PMC who *remain in* kin or non-kin foster care.

- **Diffusion of the PCA option through the child welfare system:** Frequency that adoption, guardianship with PCA, guardianship without PCA, or other is the permanency goal or concurrent goal for children in DFPS TMC and/or PMC.
- **Targeting of the PCA program by group of relative caregiver:**
  - Frequency of cases in which adoption, guardianship with PCA, guardianship without PCA, or other is the permanency goal or concurrent goal for children who remain in the state's PMC and live in *kin foster care*.
  - Frequency of cases in which adoption, guardianship with PCA, guardianship without PCA, or other is the permanency goal or concurrent goal for children who remain in the state's PMC and live in *non-kin foster care*.
  - Frequency of cases in which adoption, guardianship with PCA, guardianship without PCA, or other is the permanency goal for children who remain in the state's PMC and live in *unverified homes supported by the Relative and Other Designated Caregiver Program*.
- **Verification of New Kin Foster Homes:**
  - Number of PCA and non-PCA kin foster home inquiries each year.
  - Number of PCA and non-PCA kin foster home applications completed each year.
  - Number of PCA and non-PCA kin foster home verifications granted each year.
- **RCCL Pipeline for New Kin Foster Homes:** Of all PCA and non-PCA kin foster and adoptive home inquiries made in a given year, the share for which applications to foster care and adoptive homes were made and the share for which foster and adoptive home verifications were granted.
- **Equal Application of Variance Requests:** Number of kin foster home applications screened each year, including the number verified, number rejected, number of variance request approvals by reason/type and location, and number of variance request rejections by reason/type and location.

Tracking this information would require an adjustment to the IMPACT system and DFPS policy that differentiates a permanency goal of guardianship without the assistance of PCA payments and guardianship with the assistance of PCA payments.

## HEARING TESTIMONY

The House Committee on Human Services heard testimony on Charge 2 on May 13, 2010 at the Texas State Capitol in Austin. Testimony was provided by the Department of Family and

Protective Services and two stakeholder groups. This section summarizes public and written testimony.

#### 1. ANNE HEILIGENSTEIN, TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Anne Heiligenstein, Commissioner of the Texas Department of Family and Protective Services, provided public testimony regarding the implementation of the Fostering Connections Act in Texas on May 13.

Commissioner Heiligenstein explained that Fostering Connections is an effort to promote permanency for children and youth with an emphasis on adoption, relative care, and aging out of care. There are mandatory and optional requirements of the new federal law. Under Fostering Connections, states are now required to notify relatives about a child's removal and support options available, to reauthorize the adoption incentive program through 2013, to eliminate income tests for title IV-E adoption assistance, to make reasonable efforts to place siblings together, and to improve oversight and coordination of health care for CPS children.

In 2009, the 81<sup>st</sup> Texas Legislature enacted the optional components of Fostering Connections, which created a new guardianship assistance program in Texas and extended adoption benefits and foster-care benefits for children who enter the system after age 16. The PCA program is expected to reduce caseloads and caseworker time by reducing the duration and prevalence of DFPS PMC. Commissioner Heiligenstein noted that several years ago, Texas was fined \$4 million for a failure to comply with federal requirements to have monthly contact with the foster child and absent parents throughout the life of the CPS case. PCA is viewed as a solution to the large caseload / small staff problem that makes it difficult for DFPS staff to comply with federal caseworker visitation requirements.

Commissioner Heiligenstein reported that the PCA program offers a new permanency option for foster children that ends CPS involvement, allows children and youth to exit the child welfare system more quickly, and reduces placement disruptions. It is expected that the PCA program will stem the rate of caseload growth, reduce the number of caseworker visits that are necessary, avoid state administrative costs related to keeping a case open, and avoid local administrative costs related to keeping a CPS case open.

Commissioner Heiligenstein reported that the program will become an option for the 13,500 children in the state's PMC, including 9,600 cases where parental rights have been terminated and 3,900 where parental rights have not been terminated. However, PCA will not be available unless the court has determined that (1) a child cannot return home safely and (2) a child cannot be adopted by an interested caregiver.

Caregivers of eligible children can sign PCA negotiated agreements starting September 1, 2010 and can begin receiving payments on October 1, 2010. Before qualifying, the prospective guardian must become a verified foster home through DPFS or a private child placement agency and serve for six consecutive months. The prospective guardian must also assume legal custody of the child before receiving payments. The amount of the payment will range between \$400 and \$545 per month, and cannot exceed the foster care amount (e.g., minimum is \$674 per month). DFPS expects that for a single CPS child who remains in the system long-term, the PCA program will produce cost savings of \$75,000 over a period of 5.3 years per child in CPS placement costs alone. The estimate does not include caseworker and court costs.

As of May 13, DFPS had developed the required rules for the PCA program and were beginning the IT/Automation development process, to target recruitment for potential PCA families, and to communicate information and invite questions about the program internally and externally. Commissioner Heiligenstein believes the success of the program should be measured by the number of children successfully placed with a loving relative and the number of allegations of abuse and neglect in new placements.

## 2. CONNI BARKER, DEPELCHIN CHILDREN'S CENTER & TEXAS FOSTER FAMILIES ASSOCIATION

Conni Barker, representing DePelchin's Children Center and Texas Foster Families Association, offered statements in support of relative placements and requested more funding flexibility for providers. She recommends more flexible licensing practices for relatives, that kinship caregivers receive the same training as foster parents on trauma and attachment, and that the state seek private partners to provide PCA families with the same ongoing support that adoptive families receive.

Ms. Barker presented evidence that children in relative care fare better than those in foster care (Rubin & Downes, 2008; Wlnokur et. al, 2009). Ms. Barker feels that PCA families should have the same level of support as foster families. She stated that 10 percent of relative placements fail. At DePelchin, when relative caregivers approach DFPS with a request to remove the child, it is typically because relatives feel unable to manage the behavioral issues of children stemming from complex trauma and attachment issues. To prevent this from happening in Texas, Ms. Barker feels that relative caregivers should be trained on trauma and attachment problems and how to help children cope and recover from abuse and/or neglect.

## 3. JUDY POWELL, PARENT GUIDANCE CENTER

Judy Powell, representing Parent Guidance Center, offered recommendations for the PCA program moving forward. She asked DFPS to approach with caution the expansion of adoption services to PCA parents. Ms. Powell noted that it is expensive to train families, and many organizations have to sacrifice higher upfront costs to do so. State funding for private

providers should be flexible enough to incent providers to provide this sort of short-term training for PCA parents. Ms. Powell also recommends that DFPS work with biological parents, noting that the reunification rate has dropped to 30 percent in the DPFS data. Since most families enter the child welfare system due to neglect, it is essential that child welfare programs address this and work toward reunifying families.

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## CHARGE 3

*Determine the feasibility of instituting a comprehensive, single point of entry system to simplify and expedite the process of accessing long-term care services for the elderly and individuals with physical disabilities.*

### 1. Executive Summary

According to the Health and Human Services Commission's (HHSC) System Strategic Plan 2011-15, "at the local level, long-term services and supports are administered by multiple agencies with complex, fragmented, and often overlapping intake, assessment and eligibility functions. As a result, identifying which services are available and where to obtain them can be difficult for many individuals".<sup>1</sup> Texas' long-term care system challenges will worsen as the population needing long-term services significantly increases; the proportion of Texas' population over 60 is expected to go from 14% in 2010 to 22% by 2040.<sup>2</sup> Associated with system navigation difficulties are increasing health care costs and trends showing a preference towards home and community-based care instead of institutional care.

Texas has taken steps to deal with this challenge, including hosting sixteen roundtables throughout 2007-2008 across the state to discuss long-term care system issues and solutions. The community roundtables led to the implementation of a number of Aging and Disability Resource Centers (ADRCs). Furthermore, HHSC's 2011-15 Strategic Plan includes the expansion of ADRCs as key to improving "the way frontline workers provide information, make referrals, and track individual cases".<sup>3</sup> Since their inception in 2005, Texas' ADRCs have proven successful at bringing local long-term care entities together in partnership to streamline processes, collaborate, innovate, and simplify information and access for consumers. The Department of Aging and Disability Services (DADS) has so far established nine ADRCs and envisions them as a single point of entry (SPOE) in their communities. However, since many communities do not have an ADRC, Texas continues to lack a *comprehensive* SPOE system.

**The Human Services Committee (the Committee) finds it is feasible to institute a comprehensive SPOE system in Texas by expanding ADRCs and strengthening existing projects.** It is structurally feasible because it simply requires cooperation between existing long-term care partners and better coordination of processes. It is politically feasible because ADRCs receive widespread support due to their proven capacity to enhance and build upon the specialties of local long-term care authorities and systems. It is fiscally feasible because funding from the federal government and the state of Texas assists with start-up, technology and marketing costs, while the majority of funding—namely, fixed costs such as staffing, space and training-- come from the proportionate application of existing partner resources to the ADRC.

While expansion of ADRCs would steer Texas closer to a comprehensive SPOE system to

*simplify* the long-term care process, the inclusion of "presumptive eligibility" would further *expedite* that process for persons who are aging and individuals who have physical disabilities wishing to receive long-term care in a community setting. Currently, only nursing facilities presume eligibility for long-term care services. The wait period for entitled community care can take up to 30-45 days--90 days in some cases--until the eligibility determination has been made, whereas presumptive eligibility would speed the process to approximately a week.<sup>4</sup>

Forging long-term care partnerships through replication of the ADRC model across Texas streamlines efforts and increases efficiency, leading to potential long-term cost savings and more humanistic policy results.<sup>5</sup> Since the practice of presumptive eligibility has the potential to provide individuals a choice in settings in which to receive care, cost-savings are particularly likely in instances where consumers may choose community-based options over more expensive institutional settings. Developing a client-centered long-term care system which focuses on streamlined client access, education, ease and choice in services is better for Texas consumers, providers, community partners and taxpayers.

**While current budget constraints may limit the ability to replicate the ADRC model across the state, the Committee proposes at least one pilot ADRC in an area without an ADRC and at least one pilot testing presumptive eligibility at an existing ADRC.**

Area agencies on aging (AAAs), local Mental Retardation authorities (MRAs), DADS' Community Services regional staff, non-profits, and other local partners will collaborate to form and operate the ADRC. Such partnerships can remove duplication of activity, yet allow agencies to focus their efforts without removing essential agency responsibilities. ADRCs in Texas have been successful in part, because of their ability to adapt to the needs of their communities. In some communities the lead agency is the MRA, while in others the AAA or a non-profit agency assumes the lead. Thus, the state can have a key role in supporting and guiding the expansion of ADRCs, while leaving the technical details and adaptation of the ADRC model in each community up to the local partners.

Finally, including the practice of presumptive eligibility in at least one ADRC will allow the state to measure the effectiveness of such a policy on: (1) expediting the delivery of community services; (2) changes in consumers' decisions regarding an institutional or a community setting; and (3) the financial costs/savings to the state. It is important to measure these effects within established ADRCs in order to predict the impact of a major systems change that would include presumptive eligibility.

## **2. Defining the Problem**

Consumers in Texas face various challenges when seeking long-term services and supports. These challenges include a confusing access system, a complex eligibility process, ineffective communication among the consumer, providers and agencies, and

limited ability to choose community care over institutional care. There are a number of reasons for these challenges.

### **2.1 Complicated Access and Navigation System**

First, there are numerous entry points for consumers trying to access services, including DADS' Community Services regional offices, AAAs and MRAs. To access services and determine eligibility, an applicant may have to visit several different agencies, and use many different sites and phone numbers. For instance, for individuals who have physical and cognitive disabilities, MRAs serve as the access point for these four services and supports: Community Intermediate Care Facilities-Mental Retardations (ICF/MR), State Supported Living Centers (SSLC), Home and Community Based Services (HCS), and Texas Home Living (TxHmL).<sup>6</sup> DADS serves as the access point for the other five services and supports available to these consumers: Community Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DBMD), and Medically Dependent Children Program (MDCP). Varying access points can be especially problematic for the 855,000 individuals who are aging or have physical or cognitive disabilities, who are living below the poverty level, and are likely to face limited internet/phone access and mobility.

Second, eligibility determinations for long-term services and supports are administered by more than one health and human services agency. HHSC determines *financial eligibility* for Medicaid-funded programs (except for programs that are dedicated for individuals who receive Supplemental Security Income (SSI) or Title XX funding). DADS determines *functional eligibility* for Medicaid, Title XIX and Title XX community services. MRAs determine *functional eligibility* for general revenue funded services for individuals with physical and cognitive disabilities.

Third, consumers often have multiple case managers who do not necessarily coordinate care across agencies or communicate with one another. Ideally, there would be a single case manager assigned to work with the various entities from the beginning and would make the necessary connections between the consumer and the various service agencies. Additionally, Texas' waiver programs were designed for the needs of specific populations, so service arrays vary widely, making it difficult to communicate between the various individuals involved.

### **2.2 Lengthy Waiting Period for Community Entitlement Services**

The fourth challenge for consumers is the limited ability to choose community care over institutional care. The eligibility process for access to long-term services and supports in the community takes around 30-45 days, and up to 90 days for certain cases\* whereas,

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\* According to DADS Assistant Commissioner Gary Jesse, the average eligibility screening period is 30-45 days, but can vary by program. This period also includes the HHSC financial eligibility screening, which can vary more widely.

presumptive eligibility could potentially shorten the wait time for services to less than a week.<sup>7</sup> Many consumers need immediate care and cannot wait 30-45 days. Nursing facilities, on the other hand, provide expedited eligibility and the consumer does not have to wait for service, thus leading the consumer, in some cases, to choose nursing facility care when that might not have been their first choice.

Because Texas does not have community entitlement programs specifically for persons with physical and cognitive disabilities, presumptive eligibility would not have an effect on their waiting period, since these consumers must wait on interest lists regardless. However, many of the problems associated with the first aim of SPOE-- the need for a simpler, more cohesive system-- would improve services to this community. Furthermore, evaluating the long-term system as a whole necessitates including all long-term care populations. Therefore, while the Committee's interim charge did not explicitly identify individuals with physical and cognitive disabilities in its wording, this report includes this population.

### **3. Long-Term Care in Texas**

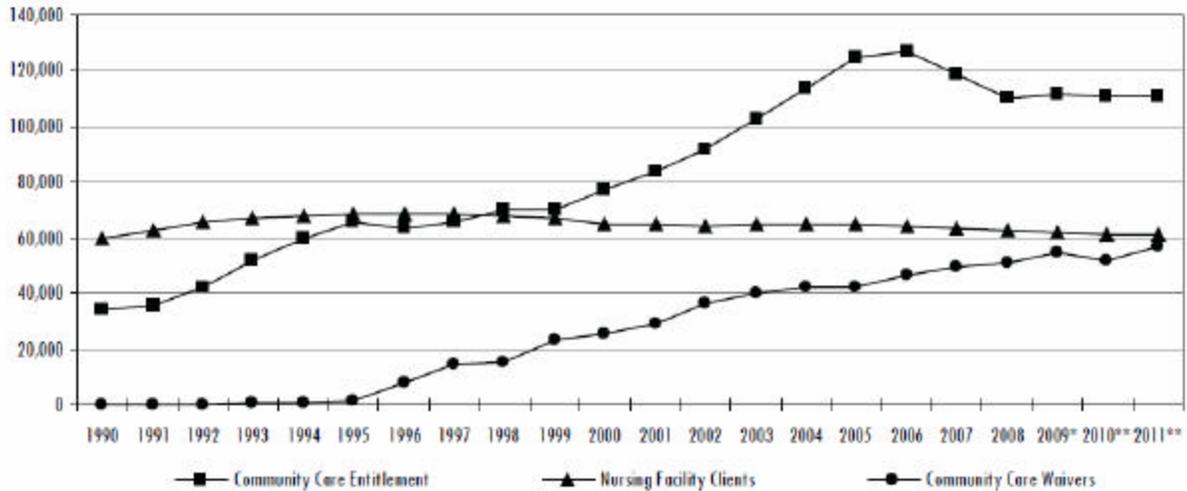
#### ***3.1 Defining Long-Term Care***

Long-term care includes medical and non-medical care which is necessary for people of various ages who have chronic illness and/or physical, developmental or cognitive disabilities.<sup>8</sup> The type and intensity of care needed varies greatly.<sup>9</sup> Generally speaking, long-term services and supports include: nursing facility care, assisted living facility care, hospice services, nursing care in the home, or help with light housework, preparing meals, grocery shopping, using money, dressing, bathing, and toileting.<sup>10</sup> Long-term care is provided in the home, the community and within institutional settings.

#### ***3.2 Long Term Care Considerations***

There are a number of factors to consider when analyzing the long-term care system in Texas. First, national trend data from the last 20 years shows that consumers are increasingly choosing long-term care in home and community-based settings over institutional settings (See **Figure 1**).

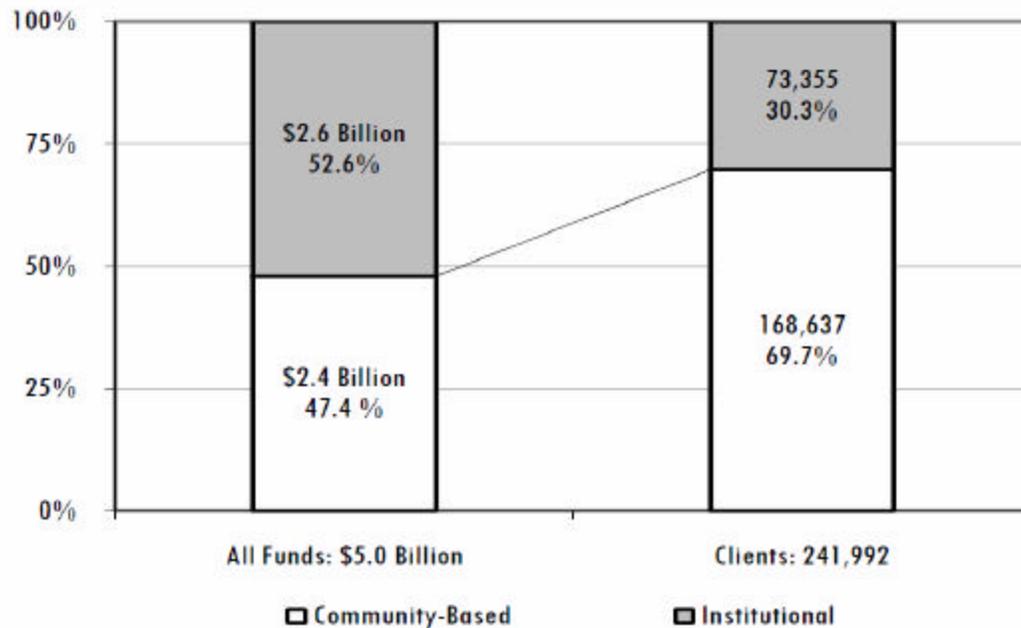
**Figure 1: Community Care & Nursing Facility Average Monthly Caseload, FY 1990-2011**



Legislative Budget Board, *Fiscal Size-Up: 2010-2011 Biennium*

Second, there is substantial evidence that home and community-based services are provided at a lower cost to the consumer and the state. As illustrated in **Figure 2**, institutional care accounts for over half of the LTC budget but only covers 30.3% of LTC consumers, while community-based care costs less and covers almost 70% of LTC consumers.

**Figure 2: Coverage and Cost of LTC Cases-- Community-based vs. Institutional Care**

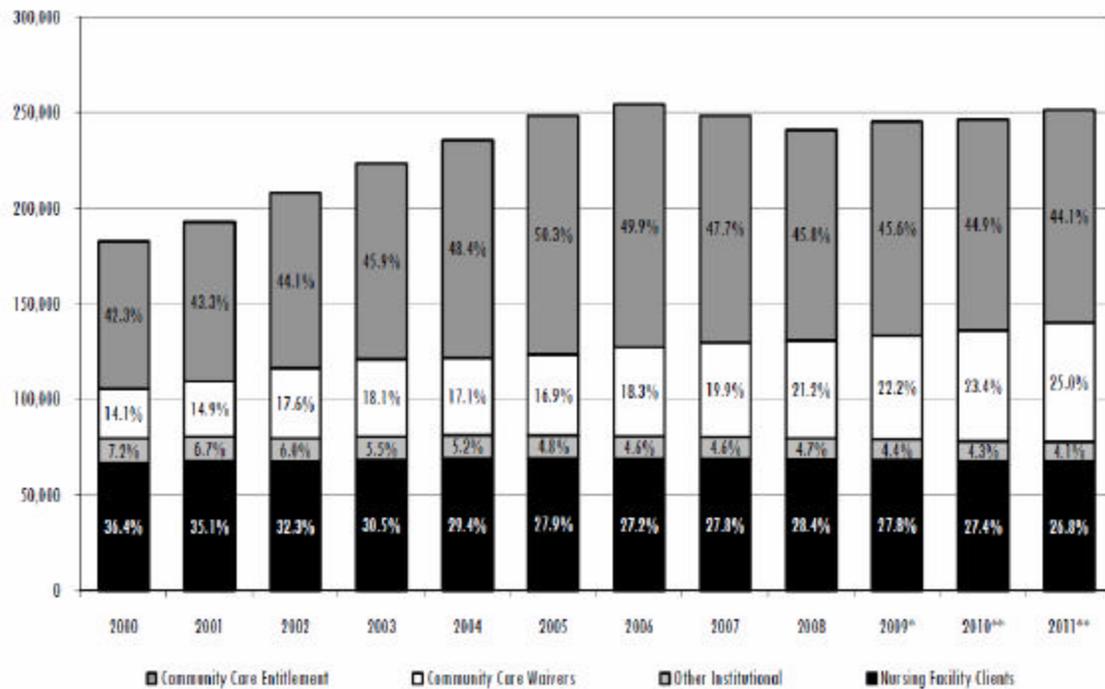


Legislative Budget Board, *Fiscal Size-Up: 2010-2011 Biennium*

Third, the United States Supreme Court's *Olmstead (1999)* decision requires States to

"place persons with disabilities in community settings rather than in institutions when the state's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."<sup>11</sup> Finally, the number of aging individuals residing in nursing facilities has declined, while this population overall has significantly increased (see Figure 3).

**Figure 3: Community & Nursing Facility Clients Proportions of the LTC Population**



Legislative Budget Board, *Fiscal Size-Up: 2010-2011 Biennium*

### 3.3 Defining the Long-Term Care Population in Texas

There are three primary populations that rely on long-term services and supports: (1) older individuals; (2) people with physical disabilities; and (3) people with intellectual and developmental disabilities. **Figure 4** lists the breakdown of the 4,588,000 Texans receiving DADS' long-term services and supports, sorted by the agency's service regions. Regions three, six, eight and eleven contain the largest percentages, respectively, of consumers living below poverty, illustrating that services are in higher demand in these areas.

**Figure 4: 2010 Texas Aged and Disabled Population by Region and Poverty Status**

Region	Total A&D Population	Aged and Disabled (A&D) Population	A&D Population Below Poverty	Percent of State Total
1 Lubbock	173000	3.77%	31000	3.63%
2/9 Abilene	266000	5.80%	45000	5.26%
3 Dallas/ Fort Worth	1074000	23.41%	157000	18.36%
4 Tyler	302000	6.58%	48000	5.61%
5 Beaumont	202000	4.40%	43000	5.03%
6 Houston	898000	19.57%	148000	17.31%
7 Austin	510000	11.12%	84000	9.82%
8 San Antonio	550000	11.99%	111000	12.98%
10 El Paso	150000	3.27%	41000	4.80%
11 Edinburg	463000	10.09%	147000	17.19%
<b>State Total</b>	<b>4,588,000</b>	<b>100%</b>	<b>855,000</b>	<b>100%</b>

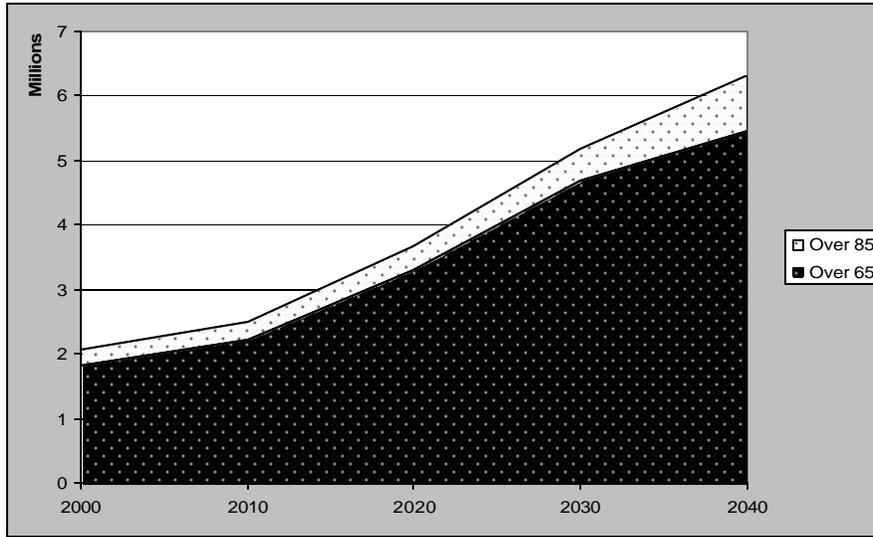
\* The aging population includes people 65 and older. The population with disabilities includes people under 65 with one or more limitations in a functional activity or a social role.

Source: Census Bureau, 2008 American Community Survey (ACS); Texas State Data Center; and Texas HHSC.

### 3.3.1 Older Individuals

As of 2010, there are 3.7 million Texans 60 years of age or older, representing 14 percent of the state's total population. This age group is projected to reach 5.4 million by the year 2020, 7.5 million by 2030, and 10 million by 2040, when it will represent approximately 22 percent of the total population (see **Figure 5**).<sup>12</sup> This dramatic increase in a demographic group for which long-term care needs are relatively common has been characterized by the Texas State Demographer as one of the principal challenges facing Texas and the nation in the 21st century.<sup>13</sup>

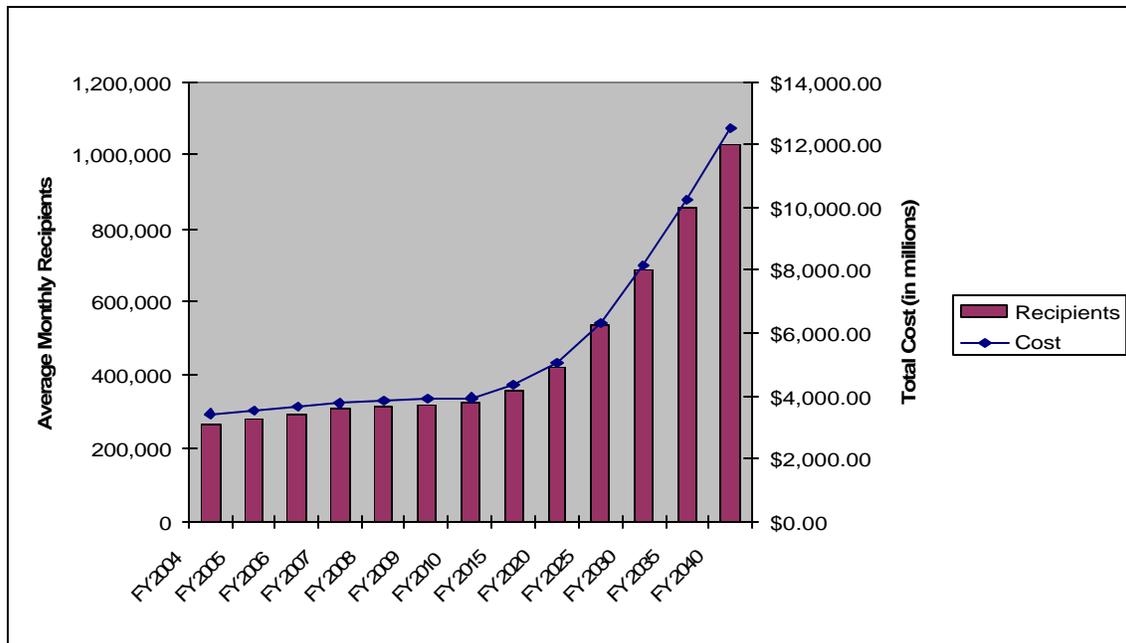
**Figure 5: Projected Growth of 65+ Population**



Source: Texas State Data Center as reported by the Texas Department on Aging<sup>14</sup>

It is important to consider the costs associated with long-term care as this population and their long-term care needs significantly increase. Currently, Medicaid pays for 67 percent of all nursing facility care, and the number of Texans eligible for Medicaid long-term care services is projected to increase 370 percent by 2040.<sup>15</sup> Long-term care services and supports are particularly crucial among this age group, as 77 percent have a disabling condition.<sup>16</sup> **Figure 6** illustrates projected growth in costs and in the number of recipients of nursing home, hospice, personal attendant, and other community care through 2040.

**Figure 6: Medicaid Long-Term Care Projections**



### ***3.4 Long-Term Care Services in Texas***

DADS and HHSC administer a number of long-term services and supports. These include Medicaid-funded, community- and facility-based entitlements, Medicaid 1915(c) waiver programs, the Money Follow the Person (MFP) program, services funded through general revenue (GR), Title XX services, and services available through AAAs.

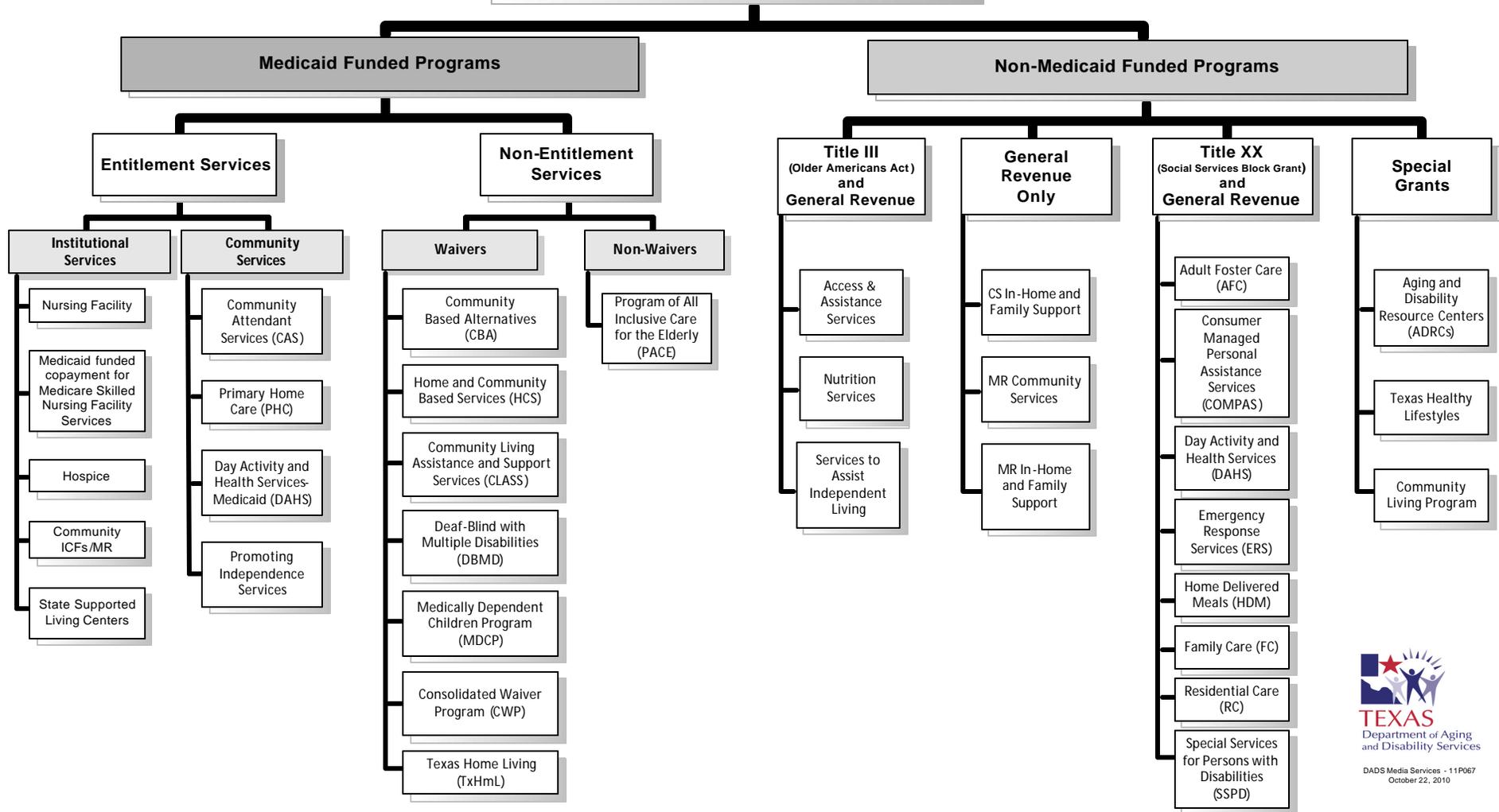
**Figure 7** (next page) provides a visual representation of the various long-term care services for the aging and disabled population.

**Appendix A** includes a break-down of Texas' various long-term care services, sorted by funding source and entitlement status.

**Figure 7: Publicly Funded Long-Term Care Services in Texas**

Texas Department of Aging and Disability Services

**Summary of DADS Services (FY2010)**



DADS Media Services - 11P067  
October 22, 2010

### 3.4.1 Entitlement Programs

The term “entitlement” means that the government cannot limit the number of eligible individuals who can enroll. Each individual who meets eligibility requirements must be served, and Medicaid must pay for any service included in the State Medicaid Plan.<sup>1</sup> States are not allowed to establish waiting lists for entitlement services. In Texas, both community- and facility-based services are included in the state plan.

### 3.4.2 Waiver Programs

Federal laws allow states to design waiver programs to address the needs of a specific population. A “waiver” is an exception to the usual Medicaid requirements, usually to provide services in home and community-based settings rather than an institution. A state must ensure cost neutrality of a waiver compared to the cost of the institutional entitlement. In contrast to entitlements, waiver programs may limit the number of persons served, hence there are usually waiting lists to access waiver programs. Three programs waive nursing facility eligibility: STAR+PLUS, CBA, and MDCP. Four waive ICF/MR eligibility: HCS, CLASS, DBMD, and TxHmL. The Consolidated Waiver Program (CWP) waives both nursing facility and ICF/MR eligibility. An individual can be enrolled in only one waiver program.<sup>2</sup>

### 3.4.3 STAR+PLUS

HHSC implemented 1915(b) and 1915(c) waivers in 1997 for Supplemental Security Income (SSI) Medicaid clients with complex needs. STAR+PLUS is based on a combined federal waiver model whereby managed care organizations are responsible for coordinating acute and long-term services and supports through the use of a service coordinator. The program now covers Bexar, Harris, Nueces, and Travis counties. It will expand to the Dallas and Fort Worth areas in February 1, 2011. As of February 2010, 166,507 individuals were enrolled in STAR+Plus services, 13,821 were receiving CBA-like services, and 4,214 were on the interest list.<sup>3</sup>

## ***3.5 Long-term Care Program Census and Associated Costs***

The table below breaks down the number of people enrolled in each program and the costs associated with each (see **Figure 8**). Based on these numbers, twice as many people are being served in the community as institutional care and it cost significantly more than community care.

**Figure 8:** Texas' Long-Term Care Client Numbers & Cost, FY 2010

**Entitlement (Medicaid) Services**

	<b>Number Served in May 2010</b>	<b>Estimated Expenditures FY 2010</b>	<b>Estimated Annual Cost per Individual</b>
<b>Institutional</b>			
Nursing Facility (Medicaid)	55,351	\$2,116,998,876	\$38,099
Medicaid funded copayment for Medicare Skilled Facility	6,493	\$155,212,961	\$23,747
Hospice	6,607	\$227,585,659	\$34,688
Community Intermediate Care Facilities-Mental Retardation (ICF-MR)	5,977	\$324,956,856	\$54,369
State Supported Living Center (ICF)	4,256	\$676,011,874	\$156,123
<b>Total</b>	<b>78,684</b>	<b>\$3,500,766,226</b>	<b>\$44,330</b>
<b>Community</b>			
Community Attendant Services (CAS)	43,630	\$410,028,743	\$9,548
Primary Home Care (PHC)	56,154	\$557,468,683	\$10,072
Day Activity and Health Services - Medicaid (DAHS)	17,712	\$112,994,166	\$6,369
Promoting Independence Services	6,359	\$116,385,531	\$18,808
<b>Total</b>	<b>123,855</b>	<b>\$1,196,877,123</b>	<b>\$9,793</b>

**Non-Entitlement Community Services**

<b>Waiver Services</b>			
Community Based Alternatives (CBA)	25,659	\$482,871,619	\$18,790
Home and Community-Based Services (HCS)	17,946	\$731,844,633	\$42,413
Community Living Assistance and Support Services (CLASS)	4,340	\$184,421,744	\$43,806
Deaf-Blind with Multiple Disabilities (DBMD)	154	\$7,347,798	\$48,985
Medically Dependent Children Program (MDCP)	2,539	\$49,158,720	\$18,720
Consolidated Waiver	161	\$3,632,923	\$22,849
Texas Home Living	883	\$8,324,074	\$8,374

Program of all Inclusive Care for the Elderly (PACE)	928	\$35,645,826	\$34,743
<b>Total</b>	<b>52,610</b>	<b>\$1,503,247,337</b>	<b>\$28,843</b>

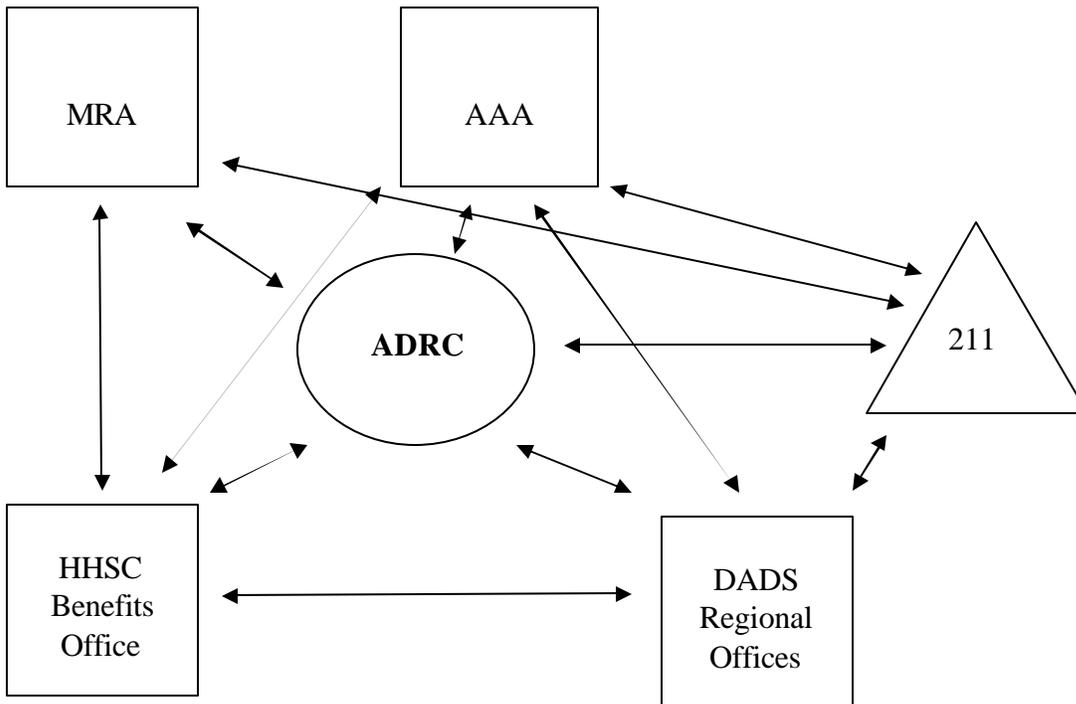
Source: Department of Aging and Disability Resources

### 3.7 Accessing Long-Term Care

#### 3.7.1 The Access Structure

**Figure 9** below visually represents the many entry points and pathways that exist as a consumer navigates the long-term care system in Texas. An individual wishing to access services could start at any one of these front doors and have to independently navigate to other entities. The visual shows how complicated the access process can become, especially for someone with multiple disabilities and needs. The circle in the middle, the ADRC, represents a possible single point of access and communication between systems, simplifying the access process and eliminating the various navigation pathways.

**Figure 9:** The Various Long-Term Care Entry Points and Navigation Avenues



#### 3.7.2 The Various Front Doors

The following explains the functions of each of the institutions in the current system.

### Aging and Disability Resource Centers

ADRCs represent an integrated front door to services. ADRCs serve any individual with disabilities—not just older persons and individuals with physical disabilities. The Administration on Aging (AoA) and Center for Medicare and Medicaid Services (CMS), original funders for the establishment of ADRCs, envision them as “highly visible and trusted places available in every community across the country where people of all ages, incomes and disabilities go to get information on the full range of long-term support options.”<sup>4</sup> ADRCs share common referral protocols and provide extensive training for community partners to facilitate referrals and service delivery.

The primary objectives of ADRCs are to: (1) support older individuals and persons with disabilities by serving as a visible and trusted source of information and assistance regarding available programs, services and benefits; (2) help consumers navigate the system of services and supports and make informed choices; and (3) to connect individuals with programs.<sup>5</sup> Key partner agencies include all three DADS front doors (DADS’ Community Services regional offices, MRAs, and AAAs) and may also include HHSC benefits offices, hospital discharge planners, mental health authorities, independent living centers and other community organizations.<sup>6</sup> The ADRC organizational structure allows a single point of contact for consumers to a variety of services and supports, as illustrated by **Figure 10**.

**Figure 10:** ADRC as the Single Point of Contact



Source: The Central Texas ADRC, Evidence-Based Programming Presentation  
H. Richard McGhee Director, Central Texas AAA, Powerpoint Presentation to the Urban Institute, September 2010

To expand on the visual above, the following examples of consumer stories illustrate the way an ADRC was able to assist them with long-term care services and supports:

Example 1:

An older veteran with diabetes caring for his grandson is in need of:

- Assistance with paying for overdue visits to the doctor for both himself and grandson
- Prescription drugs
- Heat for his home
- Food
- Help understanding his Medicare benefits

The ADRC assists by:

- Working with the local HHS benefits office to enroll him in:
  - The expedited Supplemental Nutrition Assistance Program;
  - Medicaid for himself and Children’s Health Insurance Program for his grandson; and
  - The one-time Temporary Assistance for Needy Families cash benefit for grandparents.
- Negotiating with the local gas company on his behalf to restore his heat
- Explaining to him how Medicare works and securing the Low-Income Subsidy benefits to help with premiums
- Working with the local food pantry to secure immediate food
- Scheduling medical appointments for both him and his grandson<sup>7</sup>

Example 2:

A middle-aged woman caring for her 19 year-old son with Down’s Syndrome and her 79 year-old mother with Alzheimer’s disease, needs:

- Assistance paying for medical appointments and prescription drugs for all three family members
- Someone to provide support for her mother and son when she is unavailable
- Rental assistance
- Car repairs

The ADRC assists by:

- Guiding her mother through the enrollment process for Medicare Part D benefits and the Low-Income Subsidy
- Working with the MRA to secure supported employment and other services available to her son
- Working with the local DADS office to help enroll her mother in Medicaid and secure in-home support services and respite care
- Working with Catholic Charities to secure one-time rental and car repair assistance
- Working with the local Alzheimer’s Chapter to supplement additional respite services and caregiver support<sup>8</sup>

**Texas ADRC Program Financing Structure:**

Texas ADRC Project Development is funded with two primary funding sources: (1) U. S. AoA Discretionary Grant Funds, procured through a competitive grant process, with DADS as the primary grantee and local ADRC project partners as the sub-grantee; and (2) State Unit on Aging (SUA) unexpended administration funds, Title III-federal dollars carried over from the previous fiscal year (DADS has the discretion and authority to use these funds for special projects). The amounts within each category vary from year to year, depending on the AoA annual awards and the remaining amount of SUA funds. In general, since FY 2006, ADRC local project partners have received funding as described below, beginning with the first year of new ADRC project development and implementation. **Figure 11** breaks down the financing over a 5 year period:

**Figure 11:** ADRC Financing

Time Frame	Year 1	Year 2	Year 3	Year 4	Year 5
Funding source	AoA and/or SUA	AoA and/or SUA	AoA and/or SUA	AoA funds only	SUA
Amount	Up to \$100,000	Up to \$100,000	\$60,000 – 75,000	\$50,000 – 64,000	\$50,000

In addition to the AoA and SUA funds, all ADRC projects are required to develop partnerships and identify local resources (both public and private) for additional funding and/or in-kind contributions to the development and implementation of the ADRC. All projects are required to contribute 25% local match for each year of funding. Match may include staff time, training, space, volunteers, equipment, supplies and/or cash contributions. Beyond year five, a well-established ADRC should have implemented plans for the long-term goal of local sustainability.

There are currently nine operational ADRCs and DADS plans to establish two more in 2010. Additionally, DADS is working with the ADRC State Advisory Council to develop a plan to have 20 ADRCs across the state by 2020.<sup>9</sup>

*Local Mental Retardation Authorities*

Community Mental Health and Mental Retardation (MHMR) Centers are governed by local boards of directors appointed by local taxing authorities such as cities, counties, independent school districts, hospital districts and any combination of these authorities. Centers are recognized in statute as an agency of the state, a governmental unity, and a unit of local government. <sup>10</sup> There are 39 local Mental Retardation authorities (MRA) across the state, most of which also serve as the Mental Health Authority (MHA). DADS holds a performance contract with each MRA to provide community-based services and assist consumers and families with access to Medicaid funded services, primarily

community ICF/MR facilities, HCS or TXHmL services when capacity is made available, and State Supported Living Centers.<sup>11</sup>

#### Area Agencies on Aging

DADS is designated as the State Unit on Aging, and as such, is the single state agency responsible for administering programs and services under the federal Older Americans Act (OAA). Through performance contracts with DADS, a network of 28 AAAs provides services in all 254 Texas counties. A primary function for AAAs is providing access and assistance services that help older persons, their family members, and other caregivers receive the information and assistance they need in obtaining community services, both public and private, formal and informal.<sup>12</sup>

#### DADS' Community Services Regional Offices

DADS' Community Services regional offices are responsible for maintaining "existing supports for long-term care services, programs, and field operations while partnering with other DADS programs and stakeholders to achieve an integrated service delivery system, which streamlines eligibility determination, enrollment and service delivery processes." These offices are located in eleven regions across the state and coordinate with the local AAAs and MRAs, ensuring appropriate referrals are made, with consideration given to the needs communicated by individuals at intake.

#### Texas 2-1-1

2-1-1 is a free, easy-to-remember phone number connecting callers with health and human services in their community. 2-1-1 is operated by resource specialists who have access to listings of nearly all health and human services in Texas. Information and referral is available 24 hours a day, 7 days a week throughout the year. 2-1-1 operators are responsible for directing people to a single point of access for long-term needs, but that that can be difficult because of complicated client needs and varying "front doors" in different communities. Simplifying the system-- specifically designating a single front door-- will provide 2-1-1 operators clarity when directing consumers to long-term care services and supports.

### **4. Single Point of Entry**

According to DADS, it is feasible for Texas to implement a comprehensive, SPOE system which does not require redesigning the system, but instead requires better coordination within the existing system.<sup>13</sup> Centralizing the numerous access points around a single front door would enhance the roles of current long-term care entities and allow for streamlined efforts. DADS believes ADRCs already provide this central role on a local level in the communities where they exist, and could be the basis for a statewide system.

## **4.1 Defining "Single Point of Entry"**

This report defines "Single Point of Entry" as designated (physical/virtual) sites with the following characteristics:

- (1) serving as visible, generally accepted, effective access points for individuals seeking long-term care services and supports;
- (2) fostering cooperation, communication and participation among the consumer and their family, caregivers, and varying providers-- non-profit, private and public;
- (3) streamlining processes, leading to efficient and quality service; and
- (4) promoting consumer choice in long-term care options.

Ideally, a single point of entry carries out the following key functions:

- (1) advising consumers regarding their service options;
- (2) screening individuals to determine their service eligibility;
- (3) tentatively determining financial eligibility; and
- (4) expediting, through a presumptive eligibility determination process, the delivery of supports to individuals who may otherwise access nursing facility services.<sup>14</sup>

## **4.2 History of SPOE**

### 4.2.1 Legislative Interest in Texas

The history of SPOE in Texas dates back to 2000. The 76th Legislature passed SB 374 and required HHSC to report on the "feasibility of establishing an integrated local system of access and services for elderly persons and persons with disabilities"<sup>15</sup>. The report found that "separate systems exist at the local level for accessing long-term care for aging adults, adults with physical disabilities, persons with mental disabilities, and for children with physical disabilities."<sup>16</sup>

As research for the report, HHSC asked communities to bring together local leaders and create their own "access plans" that described their vision of what an ideal system would look like in their communities and to also identify the barriers that prevented implementation of such plans. Twenty-five plans were submitted from across the state. The plans revealed some concrete lessons, which were applied to DADS' establishment of ADRCs, beginning in 2005.<sup>17</sup> The report made the following recommendations which still apply today:

- (1) *Implement single point of entry, single point of connection:* Persons seeking services can get initial information about total array of services at any entry point, and will not have to go to several locations to find out about services for which he/she is potentially eligible.

- (2) *Train and provide knowledgeable service managers to support consumers in accessing and coordinating long-term care services:* Personnel should have a broad and general knowledge of all health and human services, programs, and supports. Highly effective support systems usually separate direct services from access and service management.
  - a. Structure a consolidated, statewide service management system that leads to service recipients having one primary service manager, separate from direct services, who is able to broker services across health and human services agencies and generic providers
- (3) *Increase local control and flexibility in planning and managing service delivery:* Responsibility and authority for planning and managing service delivery should be at the local level as much as possible, in order for the service system to respond and meet local/regional needs while maintaining statewide system integrity and definition.<sup>18</sup>

More recently, during the 81st Legislative Session, two bills- H.B. 1398 and S.B. 943- were filed that that would have established pilots for a comprehensive single point of entry system, including presumptive (tentative) eligibility, wherein consumers can go to fully address their needs. HB 1398 was voted out of Committee, but it died in Calendars, and SB 943 was left pending in Committee.

H.B. 1398 and S.B. 943 would have authorized up to three pilot projects to institute a comprehensive, SPOE system to simplify and expedite the process of accessing long-term care services for persons and individuals with disabilities. HB 1398 required at least one pilot to include the physical co-location of DADS, HHSC, and AAA staff, and it also required HHSC to establish tentative eligibility at all three locations. It defined "expedited service authorization" as "authorization of services within seven calendar days based on screening of applicants and tentative eligibility for receipt of services and initiation of those services as soon as possible."<sup>19</sup> The bill required HHSC to submit a status report after two years and set the pilot expiration at 4 years.<sup>20</sup> The fiscal note estimated that 269 new program recipients would enroll in CAS, DAHS, and PHC, it did not however, include all the programs listed in the bill, since those included programs with interest lists.

#### **4.3 Current SPOE Activity**

DADS amended its Legislative Appropriations Request (LAR) to include a three million dollar exceptional item (all funds) for a presumptive eligibility pilot in Region 4. The agency chose Region 4 primarily because it operates in an area that does not include STAR+PLUS. In a STAR+PLUS service area, managed care organizations coordinate the delivery of PHC and DAHS, funded under Title XIX. However, in a STAR+PLUS area, CAS is coordinated through DADS. The agency believes the split responsibility could lead to complications for a pilot. See **Appendix B** for a list of all current ADRC locations and counties covered.

## 4.4 SPOE Benefits

### 4.4.1 Simplified, More Efficient System

A SPOE system would allow for better coordination, partnership, streamlining, and efficiency. Most importantly, it makes the process easier on the consumer and promotes consumer choice. The advantages of Texas' ADRCs as a single point of entry have been documented in program evaluation activities. These advantages include:

- a streamlined system of access;
- knowledgeable, well-trained system navigators;
- capacity to address multiple consumer needs for multiple family members;
- connects consumers to local resources, rather than relying on federal/state services, which is important during a challenging state budget period;
- capacity to provide options counseling which helps make informed choices;
- builds stronger partnerships throughout the community, allowing them to leverage resources and funds otherwise not available;
- in addition to DADS three front doors, partners include for-profit and nonprofit community agencies, faith-based organizations, charitable entities, local housing authorities, the Texas Workforce Commission, hospitals, physicians, wellness centers and universities, which better positions ADRCs to receive grant money and outside financial support; and
- a focus on "critical pathways" such as discharge planners, 2-1-1 workers, case workers, protective service workers and HHSC benefits offices, allows ADRCs to quickly identify individuals at risk of Medicaid spend-down or placement in an institution and can help consumers avoid/delay this option.<sup>21</sup>

The simplified system of navigation visually represented below, **Figure 12**, represents an example of a co-located ADRC (a virtually located ADRC would include additional partners such as hospitals, private resources, and HHS benefits offices). Compared to the complicated system diagrammed on page 12, providers, 2-1-1 operators, partners and clients will have an easier time identifying the access point and the pathways to service. Ideally, another spoke on the graphic below would be the HHSC benefits office; unfortunately, eight of the nine ADRCs do not co-locate HHSC eligibility staff.

**Figure 12** : ADRC as the Single Point of Entry



There have been numerous successes of Texas' ADRCs-- from awards, to innovative new projects, to personal consumer success stories. See **Appendix C** for a list of successes.

#### 4.4.2 Potential Cost Savings of a Single Point of Entry Model

Cost-savings would be realized from streamlined processes and the removal of duplication from the system , as well as increased efficiency, although it is difficult to say to what degree and how much. However, considering the growing demand for long-term services and supports, it is worth Texas' investment to test this concept and measure its effectiveness. Utilizing already established ADRCs as a platform could prove economical for the state in testing the potential success of a comprehensive SPOE system.

Since 2003, the U.S. AoA and CMS have partnered to provide grants to states to develop and expand ADRCs, and are requiring states to provide a plan by March 2011 for expanding ADRCs statewide. Moreover, the federal government is increasingly making a number of related grant opportunities available only to ADRCs or else which require a close partnership with ADRCs. These opportunities include: the ADRC Options Counseling and Assistance Program (\$500,000), the ADRC Nursing Home Transition and Diversion Program (\$400,000), the ADRC Evidence-Based Care Transition Program (\$400,000), and the Medicare Improvements for Patients and Providers program (\$2,661,554).<sup>22</sup>

ADRCs have demonstrated an ability to attract additional grant money for innovative projects. DADS' Community Living Program (CLP), which was originally funded in fiscal year (FY) 2009 by a \$923,708 grant from AoA, has created a partnership with the Central Texas ADRC and Scott & White Healthcare to establish a nursing home diversion program for individuals at imminent risk for nursing home placement and Medicaid spend-down. In September 2009, DADS was awarded a new \$396,600 grant from AoA to support an additional CLP between DADS, the AAA of Tarrant County and the ADRC of Tarrant County. The CLP is one example of the effectiveness of the ADRC model in attracting additional funding.<sup>23</sup>

#### 4.4.3 Legality

Implementing SPOE pilots will help Texas keep its legal obligation to serve persons in community settings whenever possible as directed by the Supreme Court's Olmstead decision.

It is not likely that CMS approval would be required to pilot SPOE, since the changes considered are essentially a reorganization in the way Texas administers intake and eligibility determination for long-term services and supports. SPOE would not represent a change in Medicaid benefits or services that would a waiver application, such as services, free choice of providers, or the geographic availability of services within a

state. In the unlikely case that a waiver became necessary, legislative language could cover and authorize the need for any waiver. Additionally, the federal government would likely grant such a waiver, due to the national prominence placed SPOE and expedited eligibility determination through Promoting Independence programs and ADRCs.

#### ***4.5 SPOE Challenges***

##### 4.5.1 Political Considerations

The main challenge with implementing a comprehensive single point of entry system is making sure local systems and entities that work well are maintained while the necessary re-organization takes place. In 2005, legislation was filed that was similar to single point of entry proposals. It aimed to reform the delivery of services at the local level and restructured many elements of the existing system. It raised concerns from a number of local long-term care entities because they believed it would remove or diminish their responsibilities and remove local authority to keep and control systems that were working well and did not need to be fixed. Initially, many were afraid the same issue would arise from the development of ADRCs, however, over time, local entities have found that their roles have been enhanced, not diminished, by the existence of an ADRC in their community.

##### 4.5.2 ADRC Challenges

Since their inception in 2005, ADRCs have identified two major challenges in Texas. First, ADRCs require continuous deployment of outreach and marketing activities to maintain itself as a highly visible and trusted entity. Second, establishing and continually developing partnerships with stakeholders, public entities, agencies, organizations and the private sector is a labor-intensive activity which requires strong leadership commitment and ongoing facilitation.

Additionally, none of the ADRCs-- except Tarrant County-- has an HHSC eligibility staff member co-located. Including HHSC eligibility staff, also known as Medicaid for Elderly and People with Disabilities (MEPD) staff, would allow for a much smoother quicker eligibility process. Many ADRCs that co-locate a DADS Community Services regional office caseworker (this staff has access to HHSC eligibility records), have found it helps speed up the financial eligibility process, but having the HHSC eligibility worker work more closely in partnership would be ideal. All nine ADRCs have Memorandums of Agreement for a designated MEPD contact person to help expedite access and troubleshoot for consumers presenting at the ADRCs.

### **5. Texas' Eligibility System**

### **5.1 Defining Eligibility and Presumptive Eligibility**

Financial Medicaid eligibility is automatically established if a person is eligible for SSI. SSI is a federal income supplement program designed to help people who are aging, blind, or have disabilities and who have little or no income. HHSC determines financial eligibility for waiver programs with the same criteria used for persons in institutional settings (income level 300% of SSI income level or \$2,022 per month for an individual). Functional eligibility is defined as an individual's requirement for assistance with activities of daily living caused by a physical or mental limitation or disability.<sup>24</sup>

Presumptive eligibility (also known as "tentative eligibility" or "expedited eligibility") means "a process by which eligibility for services is provisionally determined based on a standard screening tool that assesses both functional and financial program eligibility for receipt of services".<sup>25</sup> "Provisional" determination means that the entity that makes this determination may begin providing services on the presumption that the consumer will become officially eligible and the entity will be reimbursed by Medicaid for the services provided up to the point of official eligibility.

### **5.2 The Eligibility System in Texas**

To qualify for Medicaid-funded long-term services, an applicant must meet specified financial and functional requirements. DADS Regional and Local Services staff determine functional eligibility- based on level of ability to perform tasks of daily living - for Title XIX, and functional and financial eligibility for Title XX. MRAs determine eligibility for General Revenue funded services. HHSC determines financial eligibility (except for programs that include SSI or Title XX funding) based on financial criteria.

### **5.3 Applying Presumptive Eligibility to LTC Services (without interest lists)**

First, while DADS included a presumptive eligibility pilot in their Legislative Appropriation Request (LAR), it would require legislative direction to implement.<sup>26</sup> According to DADS, for the PHC and DAHS programs, in which individuals incomes are at the SSI level and only functional screening is required, services could be expedited by approximately 30 days. For CAS, in which the entire population has incomes above SSI and the screening includes both functional and financial eligibility, DADS estimates services could be expedited by approximately 90 days.<sup>27</sup>

Second, because there are interest lists for waiver programs, presumptive eligibility would not apply to these programs since there is a waiting period regardless. Therefore, presumptive eligibility would only apply to the entitlement community services-- PHC, CAS and DAHS.

While more than 58,000 individuals are currently enrolled in DADS and STAR+PLUS waiver programs, more than 100,400 individuals are currently on interest lists for those

services.<sup>28</sup> Time spent on the interest lists varies by program, but the wait for some programs can be as long as eight to nine years. Some of the individuals on the interest list receive other services through DADS or will never receive services because they do not ultimately meet eligibility requirements, do not respond when a “slot” becomes available, or simply decline the opening because they are happy with current services. However, there is still a large unmet demand that makes it essential that the state do all it can to ensure that services are provided in the most cost-effective manner possible. Reducing expenditures for unneeded or excessive services is critical to the agency's ability to serve a greater number of individuals who are currently on interest lists.<sup>29</sup>

#### ***5.4 Presumptive Eligibility Benefits***

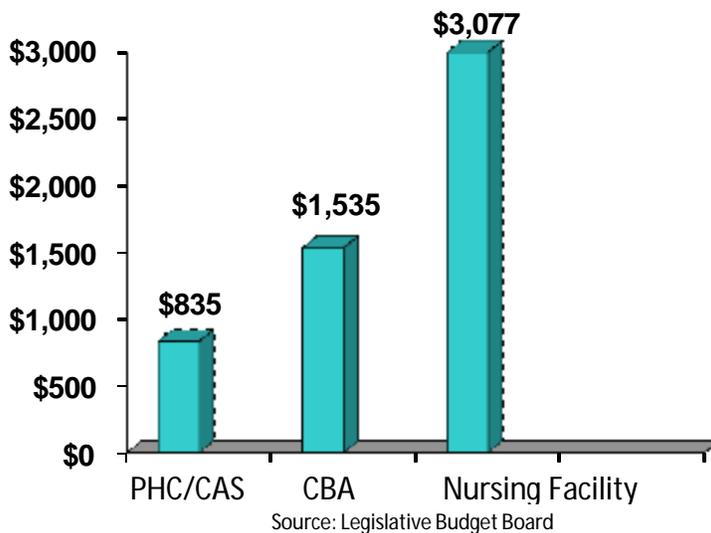
The primary benefit to the practice of presumptive eligibility is that the consumer has a real choice about whether they want to be served in the community or in an institutional setting, as the consumer will be able to receive either option quickly. Other states have found that presumptive eligibility has led to fewer nursing home placements. A Colorado pilot study found that about a third of their discharges could be diverted to community care if an expedited program was in place.<sup>30</sup> Oregon's improvements in access and start-time for community-based care has resulted in annual reduction of 401 clients per year in nursing facilities, and the offset in savings has allowed an average annual increase of 1,309 community clients.<sup>31</sup>

##### 5.4.1 Potential Cost Savings

The shift away from nursing facility care has had positive fiscal implications for Texas so far. Texas would have spent an estimated \$2 billion more in FY 2007 if the share of total clients entering nursing homes had remained at 1980 levels (67.5%) with all other factors remaining equal.<sup>32</sup> As **Figure 13** (next page) shows, nursing facility care costs significantly more than community long-term care programs. There would likely be a portion of clients diverted from a nursing home to community care.

For each potential Medicaid nursing home client that is diverted to PHC, the state pays about 27% of what it would have paid for the nursing facility care, for however many months that individual receives care at home.<sup>33</sup> For SFY 2011, average net monthly cost per Texas Medicaid nursing home resident is \$3,077 and the average PHC monthly cost is \$835. Therefore, the state would save a difference of \$2,242 each month per client, which would really add up to a lot of savings if one third of Texas 55,351 nursing home clients (May 2010 figure) were diverted to community care as the Colorado pilot found. While PHC is not an exact substitute for nursing facility care, it can substitute for some consumers with additional supports naturally provided at home.

**Figure 13: Medicaid LTC Services, FY 2011, Average Monthly Costs/Client Served<sup>34</sup>**



Presumptive eligibility programs in other states have generally proven cost effective and helped to increase funding for community care services. A University of Kansas study found a diversion program is cost effective even if as few as 20% of fast track/diverted-to-community-care clients would have otherwise entered a nursing home and stayed at least seven months.<sup>35</sup>

### **5.5 Presumptive Eligibility Challenges**

While savings will likely be realized in the long run, there are initial costs to establish the pilots and presumptive eligibility that might off-set early savings.

#### 5.5.1 Potential Costs

Based on the fiscal notes for H.B. 1398, DADS estimated the following costs to implement presumptive eligibility at three pilot sites (Note: these costs are based on *three* pilot sites and *do not include the cost-savings* that would be realized from this legislation).<sup>36</sup>

<b>Cost Description</b>	<b>State Share (GR)</b>	<b>Federal Share</b>	<b>Total</b>
Biennially-- to cover costs of medical coverage that would be realized (~45 days) earlier	\$2.7 mil	\$ 3.1	\$5.8
Estimated 5% individuals determined to be ineligible after receiving expedited service authorizations	\$112,000	0	\$112,000

According to DADS, it would cost Texas \$2.7 million biennially to cover the cost of delivering services to individuals sooner than they might have received them. However, it is not certain this population will wait for services, since they might choose other services, so this cost might not increase as much as estimated. Medicaid will not cover the costs of those determined to be ineligible; it is estimated that the state will have to cover \$112,000 worth of services for people presumed eligible that were not eligible.

Moreover, there are additional operating costs-- start-up and staffing-- to consider as described in the methodology section of the HB 1398 fiscal note. The cost of providing the AAA staff-- \$0.2 million-- would be passed through DADS as a GR expense. DADS would require 2 FTEs at a cost of \$0.1 million in each fiscal year for salaries, benefits and employee set-up costs. Information technology costs are estimated at \$0.5 million for the first year and \$0.1 for the second year. Finally, HHSC estimates it would require 7.4 FTEs at a cost of \$0.3 million per year; automation costs at \$1.3 million and ongoing contractor costs at less than \$0.1 million per year.

#### 5.5.2 TIERS Transition

The Texas Integrated Eligibility Redesign System (TIERS) will integrate the application process for more than 50 health and human services programs. TIERS is replacing several outdated systems, including the 30-year-old System of Application, Verification, Eligibility, Referral and Reporting system (SAVERR), with a single integrated system. SAVERR, which was designed in the '60s and launched in the '70s, is built on technology that is out of date and difficult to service.<sup>37</sup> The move to TIERS has significantly decreased wait times in the areas it has already been implemented. Unfortunately, there are no immediate plans to transition MEPD into TIERS. According to HSSC, the schedule for a MEPD transition to the TIERS system has not been determined.

### **6. Conclusion and Recommendations**

Based on testimony provided by stakeholders and the public, input provided by DADS, providers, advocates, and other stakeholders, SPOE legislation proposed in the past, and the underlying goal and feasibility of a comprehensive SPOE system in Texas, the House Committee on Human Services makes the following recommendations:

**Pilot at least one new ADRC in an area that does not currently have one and pilot presumptive eligibility at an existing ADRC.**

***Pilot 1: Establish at least one pilot site in an area that does not have an ADRC.***

- (1) Pilot in an area that lacks local partnership and communication between long-term care entities.
- (2) Ideally this site would be physically co-located but could be virtually co-located if

physical co-location is not feasible, due to lack of resources or other constraints.

- (3) Ideally, HHSC eligibility staff would be included in the partner model.

***Pilot 2: Establish at least one pilot site that includes presumptive eligibility, with the following requirements.***

- (1) Establish the site within an already established ADRC.
- (2) Establish within an ADRC that has staff physically co-located, and specifically co-locate
  - a. a DADS functional eligibility staff member; and
  - b. an HHSC financial eligibility staff member.
- (3) Provide expedited services for older persons and individuals with disabilities who want to access entitlement community services-- PHC, CAS and DAHS.

**Additional recommendations:**

- (1) Provide a road map for the establishment of these sites that adapts smart practices from proven, successful ADRC sites (consider the Tarrant County and Central Texas ADRCs). See **Appendix D** for a list of ADRC "Best Practices".
- (2) Use model ADRC sites to promote successful policy for establishing the pilots based on "rigorous replication of the logic i.e., the 'how' of the basic mechanisms desired, while leaving maximum flexibility as to the specific means to carry it out".<sup>38</sup> This entails leaving the technical details up to the local communities chosen for the site (ADRCs are successful, in part, because of their ability to adapt their operational design to the needs of their communities).
- (3) Use the ADRC Technical Assistance Exchange "Fully Functioning Aging and Disability Resource Centers", June 2010, criteria guidelines to assist Texas to measure and assess progress toward developing a fully function SPOE/ADRC system (available at [www.adrc-tae.org](http://www.adrc-tae.org)).
- (4) Local/regional leadership should be identified and involved in the process and include:
  - a. County Commissioner
  - b. County Judge
  - c. City Mayor/Council
  - d. Local Council of Governments Director
  - e. Other local leaders (elected and non-elected)
- (5) Local/regional leadership should engage stakeholders and solicit community

Input.

- (6) Allow local stakeholders to choose their lead agency. The ADRC is based on cooperation and collaboration of all long-term partners in the area, but one agency must take the lead. The lead agency varies by community-- for Region 4 it is the AAA, for Region 3 it is an MRA, and for Region 9 it is a local non-profit agency.
- (7) Aim for the physical co-location of ADRC partners, but allow for virtual co-location when physical co-location is not possible. Not all ADRCs exist with co-located partners; the partnership works because the ADRC model is about the process of establishing clear interagency protocols and referral practices, and not necessarily about where staff are located.
- (8) The SPOE should maintain collaborative partnerships and linkages with local government, community based organizations and the local long-term care provider community- including the local MRA, DADS staff, HHSC staff, AAA staff, and other community partners. This is in order to ensure a coordinated service delivery system that provides improved and streamlined consumer access to information and community services, maximizes the utilization of existing resources, and avoids duplication of effort.
- (9) The core functions of SPOE should include:
  - a. Information, Referral and Awareness-- use common referral protocols and extensive training for partners to facilitate referrals and service delivery.
  - b. Options Counseling, Advice, and Assistance-- including collaborations with hospital discharge planning departments to reduce hospital readmission.
  - c. Streamlined access-- service delivery models include shared data warehouse, a shared intake system, telephone systems that integrate intake through all the partner agencies and provides "warm" handoff for referrals.
  - d. Person-Centered Transition Support-- with an emphasis on evidence based interventions.
  - e. Quality Assurance and Continuous Improvement.
- (10) The name of the SPOE should include "ADRC" in the title, to better promote statewide identification and general acceptance of ADRCs as the known SPOE.
- (11) A public education and advertising campaign should be utilized to inform the community about the SPOE and available services.
- (12) Avoid conflict of interest. The lead agency should ensure that the coordination of authorization and payment for a long-term care service is separate from the direct provision of that service.

- (13) The lead agency should have written policies and procedures that clearly define operations and standards.
- (14) Consider including pilot requirements and logistics of H.B. 1398. See **Appendix E** for a list of these requirements and logistics.

## 7. Endnotes

- <sup>1</sup> HHS System Strategic Plan 2011-15. Chapter 5: DADS. Online. Available: [http://www.hhs.state.tx.us/StrategicPlans/SP11-15/Strategic\\_Plan.pdf](http://www.hhs.state.tx.us/StrategicPlans/SP11-15/Strategic_Plan.pdf). Accessed Sept. 1, 2010. p. 89.
- <sup>2</sup> Texas Department on Aging. (2003). *Texas demographics: Older adults in Texas*. Austin, TX.
- <sup>3</sup> HHS System Strategic Plan 2011-15. p. 90-91.
- <sup>4</sup> Interview with Gary Jesse, DADS Assistant Commissioner. Austin, TX. August 24, 2010.
- <sup>5</sup> Bardach, Eugene. "A Practical Guide for Policy Analysis. The Eightfold Path to More Effective Problem Solving". CQ Press, Washington, DC. 2009. p. 102.
- <sup>6</sup> Interview with Danette Castle, CEO, Texas Council of Community MHMR Centers. Austin, TX. September 22, 2010.
- <sup>7</sup> Interview with Gary Jesse. August 24, 2010.
- <sup>8</sup> The Official U.S. Site for Medicare, "What is Long-term Care?". Online. Available: <http://www.medicare.gov/longtermcare/static/home.asp>. Accessed: Sept. 20, 2010.
- <sup>9</sup> Texas House Human Services Interim Report, 80th Legislature. p. 49-86 and p. 135-153.
- <sup>10</sup> Texas Health and Human Services System website. "What Are Long-term Services?" Online. Available: <http://www.dads.state.tx.us/ltss/index.html#longterm>. Accessed Sept. 1, 2010.
- <sup>11</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).
- <sup>12</sup> HHS System Strategic Plan 2011-15. p. 93.
- <sup>13</sup> Texas Department on Aging. *Texas demographics: Older adults in Texas*.
- <sup>14</sup> *Ibid.*
- <sup>15</sup> Human Services Interim Report, 80th Legislature. p. 49-86 and p. 137.
- <sup>16</sup> Hearing on Interim Charges 2 & 5 before the Committee on Human Services, 80th Texas Legislature, Interim Sess. (2008, May 1) (testimony of Don VanRyswyk, Texas Association of Area Agencies on Aging).
- <sup>1</sup> HHSC/DADS Presentation to the Senate Health and Human Services Committee. Executive Commissioner Thomas M. Suehs and Commissioner Chris Traylor presenting. February 23, 2010.
- <sup>2</sup> *Ibid.*
- <sup>3</sup> E-mail from Nelda Hunter, HHSC Government Affairs Specialist, to Katherine Mason. Nov. 30, 2010.
- <sup>4</sup> Administration on Aging, "Aging and Disability Resource Center: The Purpose of the Program and How It Works". Online. Available: [http://www.aoa.gov/AoARoot/AoA\\_Programs/HCLTC/ADRC/index.aspx](http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC/index.aspx). Accessed: September 22, 2010.
- <sup>5</sup> DADS Human Services Committee Hearing Presentation, June 30, 2010. p. 23. Available: [http://www.dads.state.tx.us/news\\_info/presentations/HHS-06-30-10.pdf](http://www.dads.state.tx.us/news_info/presentations/HHS-06-30-10.pdf)
- <sup>6</sup> *Ibid.*
- <sup>7</sup> *Ibid.*
- <sup>8</sup> *Ibid.*
- <sup>9</sup> *Ibid.*
- <sup>10</sup> DADS "Access & Intake Services, Community Options Booklet". Prepared by DADS Community Services and Program Operations. Updated 8/3/10. Online. Available: [http://www.dads.state.tx.us/providers/community\\_options.pdf](http://www.dads.state.tx.us/providers/community_options.pdf). Accessed: September 1, 2010. p. 5.
- <sup>11</sup> Texas DADS, "Reference Guide 2010: (Per DADS Budget Strategies)". p. 7
- <sup>12</sup> DADS "Access & Intake Services, Community Options Booklet". p. 4.
- <sup>13</sup> Interview with Gary Jesse. July 26, 2010.
- <sup>14</sup> DADS Human Services Committee Hearing Presentation, June 30, 2010. p. 19.
- <sup>15</sup> Texas HHSC, "Achieving Integrated Local Access and Services for the Elderly and Persons with Disabilities: A Report to the Lieutenant Governor and the Speaker of the House as Required by SB 374". November 1, 2000. p. 1.
- <sup>16</sup> *Ibid.*
- <sup>17</sup> E-mail from Jennie Costilow, DADS Government Relations Specialist, to Katherine Mason. August 11, 2010.
- <sup>18</sup> Texas HHSC, "Achieving Integrated Local Access and Services for the Elderly and Persons with

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Disabilities". p. 5.

<sup>19</sup> H.B. No 1398. Authored by Representatives Guillen, Naishtat and Hughes. Online. Available: <http://www.capitol.state.tx.us/Search/DocViewer.aspx?K2DocKey=odbc%3a%2f%2fTLO%2fTLO.dbo.vwCurrBillDocs%2f81%2fR%2fH%2fB%2f01398%2f2%2fB%40TloCurrBillDocs&QueryText=hb+1398&HighlightType=1>. p. 2, line 3.

<sup>20</sup> Ibid, p. 7 line 4 and p. 8 line 2.

<sup>21</sup> Handout at Statewide Coalition Meeting of Texas' ADRCS, June 14, 2010. "Key Benefits to Texas for Expanding Aging and Disability Resource Centers". Online. Available: <http://www.aoa.gov/AoARoot/Grants/Funding/index.aspx>. Accessed: September 1, 2010.

<sup>22</sup> Ibid.

<sup>23</sup> Letter from DADS Commissioner Traylor to the Honorable Jane Nelson. In response to questions raised during the Health and Human Services Committee May 12, 2010 hearing. June 14, 2010

<sup>24</sup> HHSC/DADS Presentation to the Senate Health and Human Services Committee. February 23, 2010.

<sup>25</sup> H.B. No 1398. Authored by Representatives Guillen, Naishtat and Hughes. p. 3, line 12.

<sup>26</sup> DADS written response to Senate Committee on Health and Human Services "Charge #6-Stakeholder Recommendations". June 8, 2010. p.1

<sup>27</sup> Ibid, p.2

<sup>28</sup> HHS System Strategic Plan 2011-15. p. 88.

<sup>29</sup> Ibid.

<sup>30</sup> AARP Human Services Committee Presentation, June 30, 2010. Source: Mollica, 2004.

<sup>31</sup> Ibid. Source: Charles Reed, Oregon, Former Deputy Secretary, Department of Social and Health Services, Washington.

<sup>32</sup> MGT of America, Inc. "Long-Term Care Services: Trends in Service Delivery and New Approaches to Solving the Long-Term Care Crisis". Presentation to the House Human Services Committee. Tuesday October 28, 2008.

<sup>33</sup> AARP Human Services Committee Presentation, June 30, 2010. Source: DADS Key Measures, Appropriations Act

<sup>34</sup> Ibid. Source: LBB, 81<sup>st</sup> Legislature, Text of Conference Committee Report Senate Bill No. 1, Regular Session (General Appropriations Act), Article II, Page II-4 and II-6.

<sup>35</sup> AARP Human Services Committee Presentation, June 30, 2010. Source: Mollica, 2004.

<sup>36</sup> DADS Human Services Committee Hearing Presentation, June 30, 2010. p. 22. Available: [http://www.dads.state.tx.us/news\\_info/presentations/HHS-06-30-10.pdf](http://www.dads.state.tx.us/news_info/presentations/HHS-06-30-10.pdf)

<sup>37</sup> Health And Human Services, "Texas Intergrated Eligibility Redesign System" November 2006. Online. Available: <http://www.hhs.state.tx.us/consolidation/IE/TIERS.shtml>. Accessed, Nov. 28, 2010.

<sup>38</sup> Bardach, Eugene. p. 102.

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## **APPENDIX A: Long-term Care Services Breakdown**

### **Entitlement (Medicaid) Services Institutional**

#### **Nursing Facility (Medicaid)**

A facility licensed by the state in which residents receive nursing care and appropriate rehabilitative and restorative services.

#### **Medicaid Funded Co-Payment for Medicare Skilled Facility**

Medicaid pays the Medicare Skilled Nursing Facility (SNF) co-insurance for Medicaid recipients in Medicare (XVIII) facilities. Medicaid also pays the co-payment for Medicaid Qualified Medicare Beneficiary (QMB) recipients, and for “pure” (i.e., Medicare-only) QMB recipients. For recipients in facilities certified for both Medicaid and Medicare, Medicaid pays the coinsurance less the applied income amount for both Medicaid only and Medicaid QMB recipients. For “pure” QMB recipients, the entire coinsurance amount is paid. The amount of Medicare co-insurance per day is set by the federal government at one-eighth of the hospital deductible.

#### **Hospice Services**

A program of palliative care consisting of medical, social and support services provided to a person with a six-month physician-prognosis of terminal illness.

#### **Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR)**

Twenty-four hour residential and habilitation services provided in homes for groups ranging in size from six to more than 100 people.

#### **State Supported Living Center**

State facilities that provide 24-hour residential and habilitation services for people with a severe or profound intellectual disability, or people with an intellectual disability who are medically fragile or have behavioral problems.

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### **Entitlement (Medicaid) Services Community**

#### **Community Attendant Services (CAS)**

A non-technical, non-skilled service providing in-home attendant services to individuals with an approved medical need for assistance with personal care tasks. CAS is available to eligible adults and children whose health problems cause them to be functionally limited in performing activities of daily living according to a practitioner’s statement of medical need.

#### **Primary Home Care (PHC)**

Primary Home Care (PHC) is a non-technical, non-skilled service providing in-home attendant services to individuals with an approved medical need for assistance with personal care tasks. PHC is available to eligible adults whose health problems cause them to be functionally limited in performing activities of daily living according to a

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practitioner's statement of medical need.

**Day Activity and Health Services (DAHS)**

Day Activity and Health Services (DAHS) facilities provide daytime services Monday through Friday to consumers residing in the community in order to provide an alternative to placement in nursing homes or other institutions. Services are designed to address the physical, mental, medical, and social needs of consumers.

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**Non-Entitlement (Medicaid) Community Services  
Waiver Services**

**Community Based Alternatives (CBA)**

Services and supports provided to persons in their own home, an assisted living facility or in an adult foster care setting as an alternative to institutional care in a nursing facility. These services may include adaptive aids and medical supplies, adult foster care, assisted living, residential care services, consumer directed services, emergency response services, home delivered meals, minor home modifications, nursing services, occupational therapy, physical therapy, personal assistance services, respite care, speech and/or language pathology services and prescription drugs (if not covered through Medicare).

**Home and Community-based Services (HCS)**

Services and supports available in a person's own home or family home, or in a small residential program. Services include day habilitation, employment assistance, respite and specialized therapies.

**Community Living Assistance and Support Services (CLASS)**

Home and community based services and supports, such as habilitation, minor home modifications, nursing, specialized therapies, respite and case management, available for persons with developmental disabilities other than mental retardation as an alternative to institutional placement.

**Deaf-Blind with Multiple Disabilities (DBMD)**

Home and community-based services for persons who have legal blindness; a chronic, severe hearing impairment; or a condition that leads to deaf-blindness and a third disability that results in impairment to independent functioning. This program is an alternative to institutional care and offers services such as habilitation, orientation and mobility, and assisted living.

**Medically Dependent Children Program (MDCP)**

Services and supports to families caring for a medically dependent child in their home who is less than 21 years of age. These services may include adaptive aids, adjunct support services (such as those that support independent living, participation in childcare and participation in post-secondary education), minor home modifications, respite and transition assistance services.

**Consolidated Waiver Program (CWP)**

A Medicaid waiver granted under Section 1915(c) of the Social Security Act that allows Texas to provide community-based services to people who meet

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intermediate care facility or nursing facility criteria.

**Texas Home Living Program (TxHML)**

Services and supports, such as day habilitation, respite and employment assistance, for people who live in their own home or their family's home.

**Program of All-Inclusive Care for the Elderly (PACE)**

Comprehensive community-based services and supports, such as any and all health-related services, social services, in-home care, meals, transportation, day activity and housing assistance, for frail elderly persons as an alternative to nursing facility care. These services are currently available in the Amarillo, El Paso and Lubbock areas.

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**General Revenue Funded Services**

**In-Home and Family Support - Regional and Local Services (IHFS-RLS) Program**

Grant benefits to individuals with physical disabilities and/or their families to purchase services that enable them to live in the community. Eligible individuals are empowered to choose and purchase services that help them to remain in their own home.

**Mental Retardation Community Services (MRA Services)**

Services and supports, such as day habilitation, employment assistance and respite provided to assist persons to live in the community.

**In-Home and Family Support – Mental Retardation Authorities (IHFS-MR) Program**

Provides financial assistance to individuals with mental retardation and/or his family to purchase items or services that directly support the individual to live in his or her natural home; integrate the individual into the community; or promote the individual's self-sufficiency.

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**Title XX (Social Services Block Grant) Funded Services**

**Adult Foster Care (AFC)**

Services such as assistance with personal care, activities of daily living and transportation provided in a 24-hour living arrangement with supervision for persons unable to function independently in their own homes.

**Consumer Managed Personal Attendant Services (CMPAS)**

Personal assistance services to individuals with physical disabilities who are mentally and emotionally competent and able to supervise their attendant or who have someone who can supervise the attendant for them. Individuals interview, select, train, supervise, and release their personal assistants. Licensed Personal Assistance Services agencies determine eligibility and the amount of care needed, develop a pool of potential personal assistants, and provide emergency back-up personal assistants.

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**Day Activity and Health Services (DAHS)**

Daytime services provided Monday through Friday to address physical, mental, medical and social needs in a congregate setting.

**Emergency Response Services (ERS)**

Emergency Response Services (ERS) are provided through an electronic monitoring system used by functionally impaired adults who live alone or who are socially isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week monitoring capability, helps to ensure that the appropriate person or service agency responds to an alarm call from an individual.

**Home Delivered Meals (HDM)**

Delivery of a nutritious meal to a person's home to ensure at least one healthy meal per day.

**Family Care Services (FCS)**

Non-skilled attendant care services, such as home management or personal care services, available to persons with functional limitations to assist with activities of daily living.

**Residential Care (RC)**

The Residential Care (RC) program provides services to eligible adults who require access to care on a 24-hour basis but do not require daily nursing intervention.

Services include personal care, home management, escort, 24-hour supervision, social and recreational activities, and transportation.

**Special Services to Persons with Disabilities (SSPD)**

Services provided in a variety of settings designed to assist persons in developing the skills needed to live in the community as independently as possible.

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## **APPENDIX B: ADRC Locations**

- (1) Alamo Service Connection-- Bexar County
- (2) Central Texas ADRC-- Bell, Coryell, Hamilton, Lampasas, and Milam Counties
- (3) Tarrant County ADRC-- Tarrant County
- (4) Gulf Coast ADRC-- Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, and Wharton Counties
- (5) East Texas ADRC-- Gregg, Harrison, Marion, Panola, Rusk, and Upshur Counties
- (6) Lubbock County ADRC-- Lubbock County
- (7) Connect to Care-- Dallas County
- (8) North Central Texas ADRC-- Collin, Denton, Hood, and Somervell Counties

El Paso-- El Paso, Culberson, Hudspeth, Brewster, Jeff Davis, and Presidio Counties

## **APPENDIX C: ADRC SUCCESSES**

### ***2009 ADMINISTRATION ON AGING "EXCELLENCE IN ACTION" AWARDS***

- (1) Central Texas AAA/ADRC & Alamo Service Connection/Bexar Area Agency on Aging: Recipients of the Changing Lives Award

ADRCs, CLPs and VDHCBs programs require grantees to engage in person-centered and consumer-directed activities that significantly impact the quality of life for older adults, people of all ages with all types of disabilities, family members, and informal and formal care providers. Changing lives requires programs to focus on people rather than programs. ADRC, CLP and VDHCBs programs and their partners are charged with engaging in activities that empower people to maximize their strengths and abilities, achieve the goals they choose, to respect and accommodate their preferences and values, to provide access to resources and services that enable them to live independently in their chosen setting, and to develop services, supports and resources that are person-centered, consumer directed and responsive to changing needs.

- (2) Central Texas AAA/ADRC, Belton, Texas

The ADRC has successfully created and leveraged diverse partnerships to bring evidence-based programming for family caregivers to the community. Not content to "rest on their laurels" Central Texas proactively searches out to develop partnerships that will help them provide community-services enabling people to live in the community of their choice.

Evidence-based programs they currently offer to families are CDSM, Matter of Balance Fall Prevention, Central Texas Support Teams, REACH II, Savvy Caregiver and Care Transitions. They operate the CLP and VDHCBs programs and partner closely with the Rosalyn Carter Institute for Care giving and Scott & White Memorial Hospital to bring family care giving to the community. Data from their 2007-2009 grant project indicates

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a significant decrease in caregiver stress, burden and depression. Consumers benefited from less burdened caregivers.

(3) Alamo Service Connection/Bexar Area Agency on Aging (San Antonio, Texas)  
Two key initiatives were highlighted in this nomination to demonstrate the ways in which ASC has significantly impacted people's lives. In response to the deaths of two elderly sisters during an extreme heat wave, the ASC, in collaboration with numerous community-service organizations both public and private, developed education and awareness campaigns and forged working relationships that enabled the community to respond rapidly to seniors and people with disabilities affected by extreme weather conditions. Their leadership improved the safety, health and comfort of numerous seniors and people with disabilities who were coping with extreme heat. The AAA developed and conducted education and awareness campaigns about the dangers of extreme heat which is especially problematic for seniors and people with disabilities.

In another program ASC lead a community-wide initiative to ensure that seniors and people with disabilities would have safe and affordable heaters to keep them warm in the winter. ASC staff raised money and combined that with Title IIIB funds to obtain and distribute over 100 heaters to people most in need. ASC worked with faculty of a local medical school to educate and inform more than 300 seniors and individuals about the dangers of extreme heat and how to cope in extreme heat conditions.

### ***Texas ADRC Program Systems Change Successes***

- Several ADRCs are involved in the development and implementation of Evidence-Based and Evidence-Informed Interventions.

(1) Central Texas ADRC/AAA has implemented *Savvy Caregiver* classes and is currently training staff to use *Powerful Tools for Caregiving*. Central Texas will soon begin offering Chronic Disease Self Management (CDSMP) classes, developing a formal partnership with the Central Texas VA Healthcare System to train VA staff and volunteers to implement CDSMP classes in VA clinics and/or health care centers.

(2) North Central Texas ADRC (NCTADRC) sent two staff to become *A Matter of Balance* (AMOB) Master Trainers and will expand the geographic reach of AMOB. The NCTADRC is also in the process of entering into a partnership with the Arthritis Foundation (AF) to co-sponsor and provide Tai Chi classes for individuals with arthritis using an evidence-informed intervention promoted by the AF.

- Connect To Care (Dallas County ADRC) has targeted outreach to the large Korean community, which is about 80-90 thousand individuals in the Dallas/Ft. Worth

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region. The ADRC identified key partners in the community and has committed to monthly community resource presentations at well-established community events in the Korean community. The success of this intervention has led to replication of a similar project with the Vietnamese Community Council of Dallas to provide community resource training specific to the Vietnamese community, including, a monthly spot on a local radio show.

- The North Central Texas ADRC helped fund the Collin County Gatekeeper Program, an interagency collaboration that provides training to City of Plano employees on recognizing residents' needs for human services and obtaining necessary services. Training has been conducted within Plano's Police, Property Standards, and Code Enforcement divisions. The project has been successful in outreach to underserved and at-risk residents.
- To prepare for a series of workshops on resources for grandparents raising grandchildren, the North Central Texas ADRC contracted the University of North Texas for a series of grandparent caregiver focus groups. Dr. Bert Hayslip is completing his report on data collected during these focus groups. The ADRC partners will use focus group results to improve outreach, education and direct services to grandparents.
- The Tarrant County ADRC has supported the provision of a service navigator at the Harris HEB grocery store for 8 hours a week.

#### **ADRC CONSUMER SUCCESS STORIES**

- **ADVOCACY STORY**

During an initial call made to the ADRC, a consumer was upset that she no longer received her Medicaid benefits. The ADRC system navigator contacted the Medicaid Office and spoke to one of the "seasoned" Medicaid officers. The Medicaid officer later followed up with the ADRC system navigator and informed her that the consumer would receive the forms necessary to reapply for the benefits for which she qualified. Thus, the consumer's case was revisited and the Medicaid officer was ultimately able to offer her benefits, based on her situation. The consumer was relieved, as she had missed several scheduled medical appointments when she thought she no longer had Medicaid. This intervention by the system navigator re-connected the consumer to her much needed benefits.

- **EASE OF ACCESS STORY**

A young man had become quadriplegic and was required to be on a respirator for the remainder of his life. His family had been through several agencies and some more than once, trying to understand and access his public benefits. Contacting the ADRC allowed the family to identify information that was missing, incomplete, and or misunderstood.

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By pulling the pieces together, the family was able to receive the assistance they needed. An ADRC follow-up contact further revealed the consumer was deemed eligible for both Social Security and Medicaid. The family informed the ADRC system navigator that they had been trying to get help for quite some time and that it was indeed the ADRC that got them the help they needed.

- **SYSTEM NAVIGATION SUCCESS**

The ADRC system navigator received a call from a 76 year-old consumer the week of the Thanksgiving Day holiday. The caller described her immediate need for food assistance for herself and her husband. The consumer told the ADRC system navigator staff she only had enough food to last one day. She had contacted the Food Bank but was told she would need to come to their location to receive assistance. She did not have transportation or the resources to access public transportation. Both the consumer and her husband were not working and their health was poor. The Food Bank referred the consumer to the ADRC. By the time she contacted the ADRC, she reported “feeling hopeless”. The ADRC system navigator connected her to the Area Agency on Aging (AAA). The AAA was able to immediately provide her with food, as well as assign her a case worker who connected her with food stamps, Medicare, and two months of rent.

- **COMPLEX NEEDS EXAMPLE – “ONE-STOP” VALUE**

A consumer came to the ADRC smelling overwhelmingly of wood smoke. His initial reason for visiting the ADRC was to request assistance in paying for his Secure Horizons (Medicare HMO) \$20.00 per month premium. Noting the smell, the system navigator asked him if he had had a fire and he said he was heating his house with the fireplace because he could not afford the electricity. The client also stated he was raising his grandson, who is 14 years old. His daughter had substance abuse problems and simply dropped his grandson off with the papers, saying she was giving up parental rights. He added that he was a veteran who served during Vietnam, but he did not think he could get veterans benefits because he was not actually in Vietnam. Additionally, the consumer stated his blood sugar was over 300 because he did not believe he could afford the insulin. He reported falling a lot and said he had hurt his shoulder. He also appeared to need a cane. A fundamental issue for this consumer was that he did not understand his Medicare benefits and did not believe he could afford to go to the doctor. For example, he did not realize he could qualify for the Medicare Savings Program. The system navigator was able to assist him in identifying his various needs and helped him access the resources to meet the multiple needs of both him and the grandson for whom he was caring. The consumer later returned to the ADRC to allow a benefits counselor to assist him with applications for CHIP and Medicaid, Food Stamps and the one-time TANF grandparent benefit.

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## APPENDIX D: ADRC Best Practices

- streamlining access to services and supports through utilization of system navigators, creating multiple or single entry points, and utilizing information technology to simplify the referral and service coordination process;
- utilizing *care transition specialists* to assist consumers in transition from facility-based to community-based long-term care options;
- deploying consistent and highly visible outreach and marketing techniques to reach consumers;
- creating formal linkages to providers at critical pathways (e.g., hospitals, physician's offices, nursing homes) to provide education and training about community long-term services and supports for consumers transitioning out of long-term care settings;
- expanding partnerships between aging, disability and other human service networks to enhance system coordination and build capacity;
- engaging consumers and stakeholders (e.g., State Health Insurance Assistance Program [SHIP], area agencies on aging, centers for independent living, the Texas Council for Developmental Disabilities, 2-1-1 Texas, housing agencies, transportation authorities, local mental health centers, one-stop employment centers and other community-based organizations) in planning, implementation and evaluation activities; and
- developing and using performance goals and indicators related to visibility, trust, and ease of access, responsiveness, efficiency and effectiveness.

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## **APPENDIX E: Pilot Requirements/Logistics per H.B. 1398 (80th)**

The pilot project outlined in HB 1398 would have required the following

- (1) Pilot site staff make-up
  - a. one or more HHSC Medicaid eligibility determination staff member
    - i. has full access to TIERS or SAVERR
    - ii. has previously made Medicaid eligibility determinations
    - iii. is dedicated to primarily making eligibility determinations
  - b. sufficient DADS staff members
    - i. to carry out screening and authorization
  - c. sufficient AAA staff members
    - i. assist with the performance of screening and service coordination for services funded under the Older Americans Act of 1965
    - ii. identify locally funded services that support community living options
  - d. any available staff from local service agencies

- (2) Pilot site staff responsibilities
  - a. work collaboratively to inform and educate clients\* and their families
  - b. screen clients requesting long-term services
    - i. will use a standardized tool that will assess both functional and financial eligibility; and
    - ii. provides sufficient information to make a tentative eligibility determination
  - c. establish "tentative eligibility"\*\* for long-term services
  - d. provide expedited service authorization for clients not on interest lists
  - e. make final determination of financial eligibility once tentative eligibility expires

\*HB 1398 defines clients as "older persons and persons with physical disabilities"

\*\* "tentative eligibility" is also known as presumptive eligibility

- (3) Pilot site logistics
  - a. at least one site has all staff physically co-located
  - b. at least one site will be located within an ADRC
  - c. may consist of a single county or multi-county region
  - d. each site serves as a comprehensive SPOE for clients to obtain information and access services in the site's service area
  - e. design/operations will accord best practices established by the executive commissioner

- (4) HHSC status report on pilot sites required (specific deliverables listed in bill)

Pilot project expires after 4 years

## Charge 4

*Monitor the Health and Human Services Commission's progress toward improving the timeliness of Supplemental Nutrition Assistance Program (SNAP) eligibility determinations. Evaluate the impact of corrective measures already taken by the commission.*

### 1. Executive Summary

The Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program) provides monthly benefits to eligible low-income families which can be used to purchase certain food items. SNAP is a federally funded program administered by the Food and Nutrition Service (FNS) division of the U.S. Department of Agriculture, and administered in Texas by the Health and Human Services Commission (HHSC). Texas operates the largest SNAP program in the United States. In December 2010, HHSC issued a total of \$445.6 million in SNAP benefits to 3.586 million recipients.<sup>1</sup>

Recently, Texas faced challenges delivering benefits to eligible Texans within the federally required application processing timeframes. Several factors contributed to these delays. Hurricane Ike- the third costliest hurricane in the United States- resulted in a large increase in applications in affected areas and placed stress on the eligibility system. The economic downturn also increased the number of applications. From December 2009 to December 2010, the number of SNAP recipients in Texas grew from 3 million recipients to more than 3.58 million, a 21.8 percent increase. Previous years of high staff turnover and the loss of tenured eligibility determination staff also made it difficult to process applications timely. Furthermore, HHSC is in the process of transitioning from a legacy computer system to a modern, web-based system- The Texas Integrated Eligibility Redesign System (TIERS). During this transition, eligibility determination staff continue to work in two automation systems, which is inherently inefficient.

As a result of these factors, performance within the eligibility system declined considerably by the fall of 2009. In October 2009, HHSC processed 58.8 percent of SNAP applications within the federally required timeframe of 30 days, and more than 42,000 applications statewide were pending more than 60 days. To address these challenges, a number of steps were taken.

In addition, recognizing that HHSC eligibility offices were severely understaffed, legislation passed in 2009 allowed HHSC to seek approval to add up to 656 additional eligibility workers beginning September 1, 2009 (Senate Bill (SB) 1, 81R). In August 2009, HHSC submitted a request to the Legislative Budget Board (LBB) increase staffing levels under SB 1. In response to this request, the agency was directed to fill existing eligibility vacancies and was authorized to increase staffing levels by an additional 250 full-time equivalents (FTEs). Utilizing the new positions, HHSC implemented a "hire-ahead" approach which uses a higher staffing cap, allowing HHSC to fill vacancies as workers leave. This approach ensures that staffing is maintained at the highest possible level. HHSC has had a net increase of 882 field eligibility

determination staff since September 1, 2009 for a total of 8,398 statewide as of November 25, 2010.

Finally, HHSC identified several policy and process changes to improve the efficiency of application processing, including:

- Increasing the eligibility workforce
- Improving employee morale and retention
- Improving employee training
- Continuing to make business process improvements
- Resuming modernization of the eligibility system by transitioning to TIERS
- Have experienced state office eligibility staff assist with processing delinquent applications

In conclusion, HHSC has made a number of improvements to their staffing levels, computer systems, and policies that have led to a significant increase in the timeliness of SNAP applications. The complete transition to TIERS, in December 2011, should also increase efficiency. Continuing with these changes and combined efforts should ensure that Texas meets federal timeliness standards and adequately serves the people of Texas.

## **2. Background**

### ***2.1 What is the Supplemental Nutrition Assistance Program?***

SNAP helps families and individuals with low incomes and few resources to buy certain food items. The assistance is provided through a monthly benefit amount. The benefit is accessed through the "Lone Star Card," which is used like a debit card, at the cash register of participating food retailers. In December 2010, Texas issued a total of \$445.6 million in SNAP benefits to more than 3.586 million recipients, compared to \$365.99 million and 3.0 million recipients in December 2009. This is a one year increase of 21.76 percent in benefits and 18.99 percent in recipients.<sup>ii</sup> (<http://www.hhsc.state.tx.us/research/FS/201012.xls>)

Most benefit periods last for six months but some can be as short as one month or as long as three years. For most adults between the ages of 18 and 50 with no child in the home, SNAP benefits are limited to three months in a three-year period.<sup>iii</sup> The benefit period can be longer if the adult works at least 20 hours a week, except for pregnant or disabled persons who are not required to work. Expedited SNAP benefits are given to those in an emergency situation, such as:

- A family with resources worth \$100 or less, and monthly income less than \$150.
- A family with resources and monthly income that are less than the most recent monthly expenses for rent/mortgage and utilities.
- A family that includes a migrant or seasonal farm worker who has \$100 or less in resources and very little income.

## **2.2. History of SNAP Issues**

Texas has faced challenges delivering benefits to eligible Texans within the federally required application processing timeframes. These challenges were the result of several contributing factors.

In 2003, the Texas Legislature, faced with a budget shortfall and rising caseloads at state eligibility offices, directed HHSC to evaluate whether call centers would be cost-effective for the eligibility and enrollment process and to contract with a private vendor to operate the call center unless it was determined to not be cost-effective. HHSC evaluated the addition of state-run call centers and an outsourced arrangement. The agency concluded that both options would save the state money, but the outsourced model saved more. HHSC entered into a contract with the Texas Access Alliance (TAA) in June 2005 after a competitive procurement for call center operations and other eligibility-related support functions. The critical new elements in the contract included establishing call centers and moving some work that had been performed by state eligibility workers to the private sector.

In January 2006, a pilot was launched in Travis and Hays counties. The initial plan called for a full transition to the new integrated, multi-access point system across the state over a 12-month period. The rollout schedule was based, in large part, on the need to implement legislative budget decisions, which eliminated the funding for nearly 4,000 eligibility staff. The pilot was suspended in May 2006, and HHSC took back some functions from the vendor.

In December 2006, HHSC announced a plan to retain additional functions originally envisioned to be performed by the private sector and reduced the terms of the contract. In March 2007, the state and contractor reached a mutual decision to end the contract. HHSC entered into short-term contracts with key subcontractors to ensure that services would continue without disruption, and new procurements were initiated to improve service delivery. While staffing reductions were not fully realized, many tenured eligibility staff left their positions during this time.

In 2008, Hurricanes Dolly and Ike resulted in a large increase in SNAP applications in affected areas and placed stress on the eligibility system. HHSC eligibility staff in disaster areas were diverted from working regular caseloads to working on disaster applications, and eligibility staff were required to work long hours out of temporary offices.

At the same time, the economic downturn was beginning to affect Texas, also resulting in an increase in SNAP applications. For example, the number of SNAP recipients in Texas grew from 3 million recipients to more than 3.58 million, a 21.8 percent increase between December 2009 and December 2010. ( <http://www.hhsc.state.tx.us/research/FS/201012.xls> )

### **2.3 Lawsuits**

On July 31, 2009, the Texas Legal Services Center (TLSC), in partnership with the National Center for Law and Economic Justice (NCLEJ), filed a class action suit against HHSC asserting that agency did not meet federal timeliness standards regarding SNAP applications (Stacy J. Howard, et al v. Thomas Suehs). The case was dismissed on the grounds that TLSC had failed to allege a violation of federal law.

On December 17, 2009, Texas Rio Grande Legal Aid again filed suit against HHSC on behalf of seven Texas families and two non-profit organizations (Octavia Gonzalez, et al v. Thomas Suehs). In the lawsuit, Plaintiffs allege that HHSC has "by design or default," failed timeliness requirements for processing SNAP applications and recertifications as set forth in state law. On June 8, 2010, the Plaintiffs amended their claims to add a total of fifty individuals and five nonprofits as additional plaintiffs. The Plaintiffs also added new allegations that HHSC's rules, policies and practices violate a statutory duty to ensure the widest and most efficient distribution of SNAP benefits and also violate rights protected by the Texas Constitution. HHSC filed a motion to dismiss the case on jurisdictional grounds and the motion is currently under consideration by the court. At this time, the case is pending.

### **2.4 State Audit**

In December 2009, HHSC Executive Commissioner Tom Suehs requested the State Auditor's Office (SAO) to conduct an audit of the SNAP program to identify inefficient policies and procedures and to make recommendations to improve the program. The audit report was released in March of 2010. The recommendations from the audit were incorporated in HHSC's Comprehensive Management Improvement Plan.

### **2.5 HHSC's Comprehensive Management Improvement Plan**

HHSC's Comprehensive Management Improvement Plan involves several initiatives that are underway in the following three categories:

#### **Improve customer service:**

- Materials will be made available to clients to help clarify the application process.
- Phone systems in local offices have will better support client inquiries and interviews.
- Several client letters and materials have been revised to improve readability and HHSC is working with stakeholders to redesign the integrated application.
- Data is being collected on the types of services being requested in offices and processes used in other states are being reviewed to help improve customer service.
- The self- service website will be enhanced to allow clients to submit questions about the application process, and responses to the most commonly submitted questions will be posted on the site.

**Enhance technology:**

Implementation of several SAO recommendations is dependent on the transition to an automated eligibility system that supports modern technology options such as giving clients the option to look up the status of their applications and benefits on the Internet. Statewide transition to TIERS is underway and is targeted for completion by December 2011.

- Additional options for electronic verifications for client information continue to be considered to help improve efficiency in processing recertifications.
- Process for authorizing users in the key eligibility-related systems has been improved, and staff continue to work to minimize delays in processing requests.
- Scanning technology options are being reviewed to determine the most cost-effective solution to help improve management of the large volume of paper files in eligibility offices.
- Risk scoring capabilities are being assessed for potential implementation to help identify complex applications or those with a higher potential for fraud.

**Strengthen management:**

- Training improvements are underway and job descriptions are being clarified to ensure that front office staff are better able to assist clients with questions.
- HHSC is evaluating staffing needs, applicant screening, hiring process, and compensation to ensure that the hiring process is efficient and is resulting in hiring quality applicants.
- Mentoring for new hires will be improved and expanded.
- Training for new and tenured staff has been revised and is under evaluation.
- An initial set of performance indicators was established and is monitored statewide and regionally each week.
- Performance Improvement Team staff will be trained to analyze business processes and identify process efficiencies.
- HHSC will work with the Office of Inspector General to increase its ability to prevent and detect fraud.

**3. Status of SNAP Eligibility Issues and Improvements*****3.1 Payment Errors and Incorrectly Denied Benefits***

The state measures and reports to FNS the accuracy of authorized SNAP benefits. Accuracy is measured through positive and negative error rates. Negative error rates are defined as “the correctness of an action to deny, suspend, or terminate SNAP benefits and whether or not the state complied with procedural requirements.”<sup>iv</sup> In 2004, only 2.8 percent of applicants were inappropriately denied benefits, but in 2008, the rate reached 21.4 percent.<sup>v</sup> For fiscal year 2009, the federal calculation of Texas' negative error rate was 14.8 percent, above the 9.4 national average.

Positive error rates occur when the amount of benefits issued does not match the amount the individual was entitled to receive. In fiscal year 2009, Texas' positive error rate was 6.9 percent, above the national 4.4 rate.<sup>vi</sup>

### 3.1.1 Corrective Actions Taken and Progress

Texas' positive error rate had improved to 2.19 percent in July 2010, below the national standard of 3.65 percent. Similarly, the negative error rate had improved to 5.52 percent, also below the 7.64 percent national rate and well below the 2008 rate of 21.4 percent. In June 2010, FNS assessed Texas \$3.96 million for being out of compliance with federal error rate standards during the previous two years. FNS designated 50 percent of the liability amount – \$1.98 million – for new investment to improve administration of SNAP, and FNS placed the remaining 50 percent of the liability amount “at risk” for repayment if Texas' error rates for federal fiscal year 2010 are above federal tolerance levels.

Texas appealed the assessment, and HHSC and FNS reached a settlement in October 2010. FNS agreed to waive the new investment amount of \$1.98 million. In return, HHSC agreed to complete previously planned program improvements, including: telecom improvements for local eligibility offices; telephony (call center) infrastructure enhancements; and deployment of 25 wireless EBT terminals on a pilot basis to assist selected farmers markets in accepting SNAP benefits.

### **3.2 Staff Turnover and Lack of Experience**

In 2004, 10 percent of eligibility workers had less than two years of experience; by 2009, the number of staff with less than two years experience reached over 50 percent. Similarly, only 4.6 percent of supervisors had less than one year in that role in 2004, while 33 percent had less than one year's experience in 2009.<sup>vii</sup>

#### 3.2.1 Corrective Actions Taken and Progress

Staff increase : SB 1, Rider 61, authorized HHSC to seek approval to add up to 656 additional eligibility workers beginning September 1, 2009. In August 2009, HHSC submitted a request to increase staffing levels. In response to this request, the agency was directed to fill existing eligibility vacancies and was authorized to increase staffing levels by an additional 250 full-time equivalents (FTEs). Utilizing the new positions, HHSC implemented a “hire-ahead” approach which uses a higher staffing cap, allowing HHSC to fill vacancies as workers leave. This approach ensures that staffing is maintained at the highest possible level. Since September 1, 2009, HHSC has had a net increase of 882 field eligibility determination staff, for a total of 8,398 statewide as of November 25, 2010. **Table 1** below lists the fill rates for the different regions.

**Table 1: Eligibility Staffing as of November 25, 2010**

Regions	Filled Positions (9/3/09)	Filled Positions (12/3/09)	Filled Positions (3/4/10)	Filled Positions (6/4/10)	Filled Positions (9/2/10)	Filled Positions (11/25/10)	Net Change In Filled Positions (9/3/09 through 11/25/10)
<b>1-Lubbock</b>	159	213	218	213	217	221	<b>62</b>
<b>2/9- Abilene</b>	212	229	254	253	253	262	<b>50</b>
<b>3-Grand Prairie</b>	1,008	1,248	1,305	1,305	1,304	1,319	<b>311</b>
<b>4-Tyler</b>	254	269	275	281	276	279	<b>25</b>
<b>5-Beaumont</b>	228	241	249	250	250	252	<b>24</b>
<b>6-Houston</b>	1,193	1,246	1,259	1,300	1,279	1,298	<b>105</b>
<b>7-Austin</b>	638	644	652	662	666	667	<b>29</b>
<b>8-San Antonio</b>	554	643	692	705	686	704	<b>150</b>
<b>10-El Paso</b>	447	451	451	449	457	447	<b>0</b>
<b>11-Edinburg</b>	968	993	1,003	1,009	1,020	1,019	<b>51</b>
<b>Asst. Response Team*</b>	584	587	589	282	284	279	<b>-305</b>
<b>Customer Care Center</b>	274	335	334	620	614	618	<b>344</b>
<b>MEPD</b>	997	1,012	1,020	1,030	1,028	1,033	<b>36</b>
<b>Total</b>	<b>7,516</b>	<b>8,111</b>	<b>8,301</b>	<b>8,359</b>	<b>8,334</b>	<b>8,398</b>	<b>882</b>

\*Assistance Response Team (ART) includes the Centralized Representative Unit that handles Fair Hearings.

To help improve morale and retention, HHSC has implemented a staff recognition program. This program includes increased contact between state and local offices as well as staff performance awards.<sup>viii</sup>

Ongoing solutions: Although the additional staff is an important piece of HHSC’s overall strategy to improve timeliness and customer services as caseloads and application rates continue to increase, staffing alone is not the only solution. Over the past several months HHSC has identified and implemented several policy and process changes to improve the efficiency of application processing. For example, in areas facing the highest caseload volumes, cases are being grouped and worked by teams of experienced and less experienced staff. This allows more cases to be processed with the same amount of resources and provides clients with access to benefits within the same day or the following day. In addition, state office staff with eligibility experience is assisting in processing the delinquent applications.

HHSC is also working to expand and improve the assistance provided through its contracts by partnering with a number of community-based organizations. The goal is to ensure that in assisting individuals with filing HHSC benefit applications those entities collect complete application packets with all necessary documentation to submit to HHSC eligibility offices. This helps reduce the amount of processing time required of HHSC staff to determine eligibility.

### **3.3 Applicant Case Backlog**

SNAP applications that were processed timely reached a state fiscal year low of 57.5 percent in November 2009. The number of SNAP applications that were delinquent-- meaning over 30 days old-- reached a state fiscal year high of 42,081 (65 percent) in October 2009.<sup>ix</sup>

#### 3.3.1 Corrective Actions Taken and Progress

Food Bank Interview Pilot: Under a demonstration waiver approved by FNS, the community partner interviewer pilot allows food banks' contact with applicants to count as the required SNAP interview. Since these interviews previously could only be conducted by state eligibility staff, the pilots assist in reducing workload for eligibility offices. State staff continue to determine eligibility and issue benefits after reviewing the applications for completeness and follow-up with applicants directly for any other information needed to make the eligibility decision. The pilot began in March 1, 2010 with food banks in Dallas, Fort Worth, Houston and San Antonio. As of November 29, 2010, a total of 14,460 interviews had been conducted. Data from the pilot shows positive results on client satisfaction, timeliness and low incidence of errors.

Streamlining for Supplemental Security Income SNAP recipients: With federal approval, elderly SNAP recipients with stable incomes were transferred to a waiver project which removed the interview requirement. This policy change eliminated the need for 20,000 interviews statewide each month, freeing up time for other SNAP recipient interviews.

Processed dual certifications for delinquent applications: In cases pending more than 60 days, applications were processed and certified for both the original application date and for a subsequent full eligibility period.

Telephone interviews for initial applicants: HHSC implemented policy which allowed required interviews to be conducted by phone rather than in-person. Funding and capital budget authority was secured during fiscal years 2008-2009 to install new phone systems at 152 sites throughout the state between December 2008 and August 2009. Since April 2010, 42 priority sites have received upgraded capacity and/or have been refreshed. Statewide implementation for all phones is targeted for April 2012.<sup>x</sup>

Lead time reduction: Applications are more likely to be processed in less than the 30-day federal standard when eligibility offices are able to decrease lead time-- the time it takes to process an application and interview a client-- to 20 days or less. Since December, 2010, all 314 eligibility offices have lead times of less than 20 days. For the week ending December 3, a total of 185 offices had lead times of less than 8 days, 123 offices had lead times between 8 and 14 days, and 8 offices had lead times between 15 and 19 days.<sup>xi</sup>

Streamlined training: Training time for new employees was accelerated from 40 days to 30 days, which includes policy and TIERS system training.

Comprehensive Management Improvement Plan (CMIP): CMIP incorporates HHSC initiatives and recommendations from the State Auditor's report and other external and internal reviews, to improve timeliness, accuracy and efficiency in eligibility determinations. It encompasses 60 recommendations and more than 70 related project plans. For example, HHSC surveyed 500

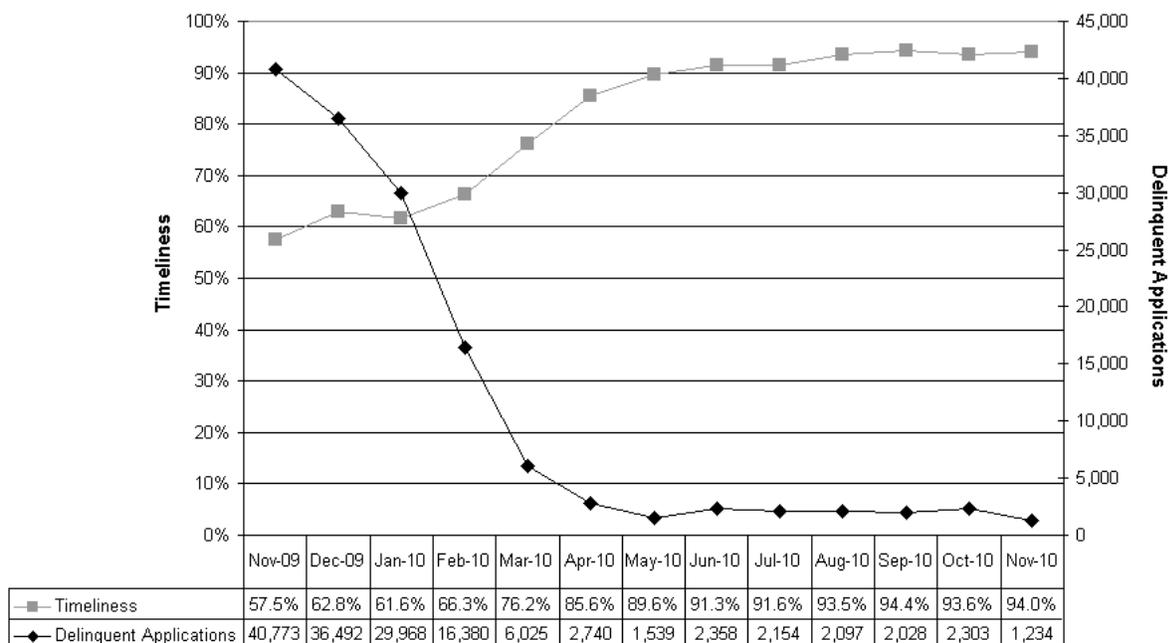
clients and clerks in 40 offices to identify communication improvements. The results are being used to develop a client communication and outreach plan.

Same Day Next Day (SDND) process: In September 2009, HHSC offices implemented a streamlined SDND process in which applicants are interviewed the same day or next day they apply. As a result, applicants do not need multiple visits to the office to complete the application process, and workloads are processed more efficiently. Statewide, 207 of 315 offices are using SDND as of September 2010.<sup>xii</sup>

Eight of the ten regions cleared their overdue cases as of February 2010, and all backlogs were cleared by May.<sup>xiii</sup> By November 2010, timeliness was up to 94.0 percent from 57.5 percent in 2009, and all ten regions are processing applications timely. Delinquent SNAP applications decreased to 1,234 (6.5 percent of pending applications) in November 2010 from 42,081 (64.7 percent of pending applications) in 2009.<sup>xiv</sup> Timeliness for recertifications increased to 96.2 percent in November, compared to 69.3 percent in December 2009. At the federal standard of seven days for expedited applications, timeliness was at 94.3 percent in November, compared to 87.3 percent in December 2009. At the state standard of one business day, timeliness for expedited applications reached 90.3 percent in November, compared to 76.2 percent in December 2009. **Figure 2** below illustrates the delinquent case and timeliness improvement over the past year.

**Figure 2: November 2009- November 2010 SNAP Timeliness and Delinquent Applications**

**Statewide SNAP Application Timeliness Compared to Number of Delinquent SNAP Applications\***



\*For Number Delinquent, SAVERR cases only are reflected through May 2010. TIERS cases included effective June 2010.

#### 4. TIERS Rollout

TIERS will replace the 30-year-old SAVERR eligibility system. TIERS will increase the number of access channels available for those applying for services and enable clients to obtain information about their benefits through automated systems rather than only through their local benefit office.

Staff in regions where TIERS has not been rolled out are currently managing cases in both SAVERR and TIERS. After TIERS is rolled out in those regions, staff efficiency and morale is expected to increase due to working in a single eligibility system. Based on Texas' previous TIERS rollouts and the experience of other states, Texas identified the following criteria as key to a successful transition to TIERS:

1. Designate a clear leader to coordinate and drive rollout activities across key areas of the agency.
2. Coordinate across the agency to define the rollout resource schedule and verify that the appropriate hardware, software, training and support resources are available when you need them.
3. Manage change and expectations. Communicate early, get staff buy-in, and engage them throughout the process. Provide feedback mechanisms for staff and stakeholders.<sup>xv</sup>

##### 4.1 Status

As of December 2010, HHSC successfully converted half of its 10 regions to TIERS, and 31.5 percent of all cases statewide, including SNAP, TANF and all Medicaid programs are in TIERS. Performance indicators for timeliness and quality control demonstrate favorable comparisons between TIERS and SAVERR, and post-conversion follow-up with field staff indicates satisfaction with TIERS, while field staff in non-TIERS regions have indicated eagerness to work in a single system. Conversion of Region 2/9 (Abilene) to TIERS is scheduled for January 2011. HHSC's goal is to complete the statewide conversion to TIERS by December 2011.

Regions Converted in 2010	Conversion Dates	Pre-Transition Timeliness Rates SNAP		Post-Transition Timeliness Rates SNAP	
		Applications	Renewals	Applications	Renewals
Lubbock – Region 1	May 2010	90.1%	93.2%	90.5%	96.2%
El Paso – Region 10	July 2010	85.1%	93.1%	90.7%	95.6%
Beaumont -- Region 5	October 2010	88.9%	96.1%	90.1%	94.2%
Tyler - Region 4	November 2010	92.5%	95.0%	95.5%*	97.0%*

\*.Based on preliminary timeliness reports released December 16, 2010

In addition, HHSC continues to implement ongoing usability enhancements. For example, in August 2010, HHSC implemented 20 significant TIERS usability enhancements for workers. These changes include calendar pop-ups so staff can more easily enter dates, more intuitive wording for required items, highlighted sections showing the worker where an error has occurred in data entry, and improvements in the layout of the screens and navigation buttons. HHSC also is enhancing the self-service options which will allow callers with cases in TIERS to obtain additional information about their case. HHSC will expand the capabilities of the current self-service website that allows individuals to complete and submit an application for benefits via the Internet. Enhancements will be developed to allow information entered into the online application to feed directly into TIERS, which eliminates the data entry currently required by state staff. The enhancements will be implemented in early 2011.<sup>xvi</sup> Also, to maintain current gains, and as required by HB 3859 (81R), HHSC completed a recent analysis of state and contractor staffing needs for the enhanced eligibility system and expansion of TIERS. HHSC determined that 1,932 additional staff would be required to meet increasing caseloads and to reduce overtime to sustainable levels. **Figure 3** below shows the projections for staffing levels needed for state fiscal years 2011-2013 for eligibility offices and centralized units.

**Figure 3:** Projected Texas Eligibility Staffing Needs

	Advisor II-III	Advisor IV	Clerks	Supervisors	Total Staff	Change	Estimated Caseload
Current	4,772	613	1,586	447	7,418	-	2,648,000
FY 2011	5,730	1,010	1,790	530	9,060	1,642	2,911,000
FY 2012	5,840	1,030	1,790	540	9,200	140	2,993,000
FY 2013	5,960	1,050	1,790	550	9,350	150	3,054,000

Another example of ongoing improvements includes HHSC 's coordination with the Office of the Attorney General (OAG) to create direct access to OAG child support information via the data broker inquiry. This change will help reduce errors related to income calculations in cases involving child support income or payments. Implementation is planned for January 2011.<sup>xvii</sup> HHSC will continue to monitor feedback and evaluations to make improvements as needed.

**5. Conclusion**

When faced with growing caseloads and a decline in performance, HHSC, with direction from the State Legislature, implemented a comprehensive approach to improve SNAP application processing timeliness that included:

- Increasing the eligibility workforce
- Improving employee morale and retention
- Improving employee training

- Making business process improvements
- Getting into a single eligibility system by resuming the transition to TIERS

The business process and policy enhancements resulting from this effort have led to improvements in application processing timeliness, reductions in payment errors and increased employee morale and retention. HHSC will continue monitoring feedback and evaluations to make enhancements addressing timeliness and customer service needs even as caseloads continue to increase.

## **6. Recommendations**

Based on the findings of the committee, the following recommendations are made:

1. Continue assessing the eligibility system to improve business processes .
2. Complete transition to statewide rollout of TIERS.
3. Monitor progress of the public-private partnership between HHSC and local food banks and include expansion to a food bank in a rural area.
4. Continue implementing and improving the policies and processes outlined in HHSC's Comprehensive Management Improvement Plan.
5. Consider increasing eligibility staff to handle increasing SNAP caseloads and maintain performance levels. If budget limitations do not allow for increased staff, take measures to ensure processes are streamlined and system efficiency continues to increase to meet demand.

## **7. Testimony : Public Testimony and Comment**

The House Committee on Human Services heard testimony on its fourth interim charge at a hearing on March 23, 2010, at the Texas State Capitol in Austin. Testimony was provided by HHSC and the Texas Food Bank Network. The following section summarizes testimony and comments received by the committee relating to SNAP.

### ***7.1 Texas Health and Human Services Commission***

On March 23, Tom Suehs, Executive Commissioner of HHSC, provided testimony regarding the performance of SNAP. In his testimony, Commissioner Suehs says that SNAP has been under criticism in the past years for failing to process applications in a timely manner, but that most of the programs failings were a result of understaffing and increased caseload due to multiple hurricanes and the economic downturn.

From 2008 to 2010, Texas' SNAP program saw an 82% increase in benefits going out and a 42% increase in recipients. As a result of these increases, the program failed to meet the federal standard of 95% timeliness and 30-day processing time. However, after HHSC hired 850 additional eligibility staff, including the 250 staff positions the Legislative Budget Board agreed

to fund, and made needed changes to the application process, many improvements took place. Commissioner Suehs listed the following improvements:

- No eligibility offices with more than 40 days lead time
- Timeliness up to 76.2% in March from 66.3% in February
- A federally acceptable, average backlog for most offices

To ensure SNAP continues to make progress in reaching federal standards, Commissioner Suehs discussed the following plans to keep SNAP on track, including:

- Hiring more staff to compensate for high turnover rates – “hiring ahead”
- Merit pay and bonuses for staff who have more years experience with the program
- Streamlining the training for new staff to include less class time and more hands on experience
- Opening channels for both staff and consumers to contact HHSC to report problems or suggestions
- Moving central office staff to eligibility offices to help with application processing and to gain experience
- Using food banks as additional contact points for consumers and to assist in properly completing applications

Stanley Stewart, Deputy Chief of Staff for Eligibility Integration, also testified on behalf of HHSC at the March 23, 2010, hearing. Commissioner Suehs hired Mr. Stewart from Michigan to oversee the rollout of the TIERS eligibility system, because he had been key to Michigan's successful rollout. Mr. Stewart described the conversion process from the SAVERR eligibility system to TIERS. Mr. Stewart explained how the conversion from SAVERR, in use since the 1970s, to TIERS benefits eligibility staff because it is easier for staff to use and manage and will help increase efficiency. Mr. Stewart stated that with 79% of eligibility cases on the SAVERR system and 21% on TIERS, some staff have received training and are working in both systems, which can create confusion between the systems. Mr. Stewart outlined the following steps that would be necessary to complete the conversion:

- Rollout readiness is assessed based on the following criteria:
  - Server capacity is sufficient to support TIERS performance
  - Offices have adequate equipment to support their use of TIERS
  - Conversion dry runs comparing the benefits issued by SAVERR and those issued by TIERS yield a benefit match rate of greater than 80 percent
  - Major TIERS system maintenance service requests are below 100
  - All staff in the office are trained in TIERS
  - Offices are current with processing
- Following each rollout, ongoing performance is gauged through:
  - Daily conference calls with local staff, management and programmers for the first month after rollout

- Daily monitoring of technical performance
- Comparisons of total benefits issued before and after each conversion
- Lead time and timeliness at each office (newly converted offices maintain experienced TIERS workers to assist with cases as needed)
- Worker feedback and evaluation
- Evaluation of client complaints
- Frequent communication with the regions

By completing these steps and keeping lines of communication open between state and local eligibility offices, Mr. Stewart said TIERS will make eligibility determinations and case management easier to handle, ensuring that Texas meets the federal requirements for SNAP.

### ***7.2 Texas Food Bank Network***

Under a demonstration waiver approved by FNS, the community partner interviewer pilot allows food banks' contact with applicants to count as the required SNAP interview. State staff continue to determine eligibility and issue benefits after reviewing the applications for completeness and follow-up with applicants directly for any other information needed to make the eligibility decision. The pilot began in March 1, 2010 with food banks in Dallas, Fort Worth, Houston and San Antonio.

On March 23, Eric Cooper, Executive Director of the San Antonio Food Bank, testified at the House Human Services Committee hearing regarding the pilot program to make food banks an initial contact point for consumers of SNAP. In an effort to assist with the timeliness of SNAP applications, Mr. Cooper stated that a pilot program was put into action in Dallas, Fort Worth, San Antonio and Houston. The program allows Food Banks to provide SNAP applications, assist in filling them out and to conduct the federally required interview. He pointed out that there are many apparent benefits to the program so far; candidates do not have to make as many trips to state eligibility offices to determine if their applications were filled out correctly, freeing state staff and allowing them to focus efforts on processing applications. If the pilot program turns out to be successful in assisting eligibility offices and SNAP candidates, the program could be extended to include all 19 Texas food banks which serve 3,300 non profits and 480,000 people per week, of which only 31% are currently receiving SNAP benefits.

## 8. Endnotes

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- <sup>i</sup> Health and Human Services Commission, *Monthly Snap Food Benefits Cases and Recipients by County*. December 2010. Online. Available: <http://www.hhsc.state.tx.us/research/FS/201012.xls>. Accessed: December 10, 2010.
- <sup>ii</sup> Health and Human Services Commission, "Presentation to the Health and Human Services Committee and Joint Committee on Oversight of the Health and Human Services Eligibility System". September 8, 2010. p. 4.
- <sup>iii</sup> Health and Human Services Commission, "SNAP Food Benefits". Online. Available: <http://www.hhsc.state.tx.us/help/food/foodstamps/index.html>. Accessed: December 8, 2010.
- <sup>iv</sup> Health and Human Services Commission, "HHSC Progress Report on Eligibility Determination System Performance". October 2010. p. 5.
- <sup>v</sup> Texas Impact, "SNAP Update". Online. Available: <http://texasimpact.org/snap1209>. Accessed: December 8, 2010.
- <sup>vi</sup> Texas Impact, "SNAP Update".
- <sup>vii</sup> HHSC Progress Report on Eligibility. October 2010. p. 1.
- <sup>viii</sup> *Id.*, p. 7.
- <sup>ix</sup> *Id.*, p. 3.
- <sup>x</sup> Health and Human Services Commission, "Health and Human Services Eligibility System Updates". October 2010. p. 3.
- <sup>xi</sup> Health and Human Services Commission Presentation. September 8, 2010. p. 8.
- <sup>xii</sup> Health and Human Services Commission, "Health and Human Services Eligibility System Updates". October 2010. p. 4.
- <sup>xiii</sup> HHSC Progress Report on Eligibility. October 2010. p. 3.
- <sup>xiv</sup> *Id.* p. 3.
- <sup>xv</sup> *Id.* p. 10.
- <sup>xvi</sup> HHSC Eligibility System Updates". October 2010. p. 5.
- <sup>xvii</sup> *Id.* p. 4.

## CHARGE 5

*Analyze the practice of using informal or voluntary caregivers ("parental child safety placements") during a Child Protective Services investigation. Study and make recommendations regarding:*

- A) efforts to track data related to parental child safety placements;*
- B) incorporation of the power of attorney process authorized by SB 1598 (81R);*
- C) appropriateness of voluntary placement;*
- D) review of caregiver qualifications;*
- E) potential improvements to the voluntary placement process.*

### EXECUTIVE SUMMARY

The Parental Child Safety Placement (PCSP) is a written agreement that allows a child to move in with a relative or caregiver during an CPS abuse and neglect investigation and/or family treatment period. This charge provides an overview of how PCSPs are positioned in the CPS abuse and neglect case, agency rules for the use of PCSPs, and problems with the current implementation of PCSPs. Based on its review of policy, the Committee recommends that DFPS:

- Designate a specific PCSP start and end date *or* establish discussions at regular intervals in which CPS, parents, and caregivers are allowed to renew or revoke the PCSP.
- Create a standardized PCSP form to improve consistent state-wide implementation of PCSP arrangements.
- Specify how background check information should be used to screen PCSP homes.
- Establish safety guidelines for potential PCSP homes.

### THE CHILD ABUSE AND NEGLECT CASE

The child abuse and neglect case consists of four major stages - intake, investigation, treatment and/or court action, and placement - and each stage incorporates a number of different stakeholders. PCSPs are applied in the investigation and treatment stages, and more information on these stages is presented in the following section. A general overview of the child abuse and neglect case is provided as part of Charge 2.

### FOCUS ON INVESTIGATION AND TREATMENT

The objectives of the CPS investigation are to determine if the child is safe, if abuse or neglect has occurred, if the child is at risk of future abuse or neglect, and if the child and family require services. During this time, the CPS caseworker collects information about the family and visits

the home to conduct a safety assessment and risk assessment. In some cases, in order to ensure a child's safety, the CPS caseworker may work with the family and other caregivers to develop a safety plan. When a child's safety cannot be secured in the home or with extended family and friends, CPS may petition the court to remove the child from the home, remove a perpetrator from the home, or obtain a protective order.

#### INVESTIGATION

Texas Family Code states that the primary purpose of the investigation is child protection (Texas Family Code §261.201(d)). CPS initiates the investigation by contacting the victim, a protective parent or caregiver, or another important person in the life of a child (CPS Handbook §2232.6). During the investigation, a CPS caseworker conducts background checks of the alleged perpetrator, interviews and examines the abused or neglected child, interviews and examines other children in the home, and interviews the perpetrator of abuse and neglect, other caregivers, teachers, neighbors, and family friends (CPS Handbook §2224.1).

CPS rules require timely investigations. High-risk, Priority I case investigations must begin within 24 hours of the report of abuse or neglect and must include local law enforcement (CPS Handbook §2223.2, SB 669 (78R)). Priority II case investigations must begin within 72 hours of the report.

The CPS caseworker uses findings from the investigation to determine the disposition of the allegations of abuse and neglect, assigning one of following (CPS Handbook §2224.3):

- **Reason to Believe/Confirmed** - preponderance of evidence indicates that abuse or neglect has occurred (24% of 2009 completed investigations)
- **Ruled Out/Unconfirmed** - based on available information from a thorough or abbreviated investigation, it is not reasonable to believe that abuse or neglect has occurred (63% of 2009 completed investigations)
- **Unable to Determine/Unconfirmed** - there is not a preponderance of evidence indicating abuse or neglect, and it is not reasonable to believe that abuse or neglect has occurred (11% of 2009 completed investigations)
- **Unable to Complete/Unconfirmed** - no conclusion can be reached because a family cannot be located to begin the investigation, the family has been contacted but subsequently moves, or the family refuses to cooperate and a Court Order in Aid of Investigation is denied (2% of 2009 completed investigations).

In Fiscal Year 2009, the state completed 165,444 child abuse and neglect investigations, ruling reason-to-believe/confirmed in 40,126 cases and unconfirmed (ruled out, unable to determine, or unable to complete) in 125,318 cases (DFPS Databook, 2009, 38). The number of child victims in confirmed cases was 68,326.

## SAFETY ASSESSMENT

The safety assessment is completed within seven days of the start of an investigation, using information from the intake report, criminal background checks, and investigation findings to determine if a child is safe at home. Considering two questions: (1) Is the child in present danger of serious harm? and (2) Is the present caregiver able to keep children safe from serious harm?, the CPS caseworker makes one of four determinations. Each is associated with a different state intervention:

- **Safe** - If the child is safe in the home, then no safety plan is needed, the child remains home, and the family is referred to services.
- **Conditionally Safe** - If there is present danger of serious harm that cannot be prevented at home, but safety can be achieved through a family's cooperation and participation in safety services or a change in living arrangements, then CPS develops a safety plan for the family. In 2009, 53,271 cases involved a safety plan (DFPS, June 15).
- **Not Safe** - If there is present danger of serious harm that cannot be prevented in the home and there is no other way that DFPS can ensure child safety in the home, CPS seeks removal and temporary conservatorship in court. In 2009, 12,107 cases involved a removal (DFPS Databook, 2009).
- **Safety Assessment Not Applicable** - This disposition is recorded if a safety assessment cannot be completed in the first 7 days due to insufficient information (e.g., family leaves town, does not cooperate during investigation), case closure, or other special circumstances.

A safety assessment is *not* completed in the following cases: if the case is administratively closed, if the investigation is given the disposition Unable to Complete, if the investigation is school-related, or if the investigation involves a child who has died (DFPS, August 26).

## SAFETY PLAN

A **safety plan** is required when a home is found to be "conditionally safe" for a child. In 2009, a safety plan was used in 53,271 child abuse and neglect cases. The use of a safety plan to protect child safety is much more prevalent than court-ordered removals (12,107 of 2009 cases).

The safety plan is a time-limited, voluntary, written agreement between DFPS and the family that specifies actions required to ensure a child's immediate safety. The safety plan might include any number of actions, for instance, providing protection for a child at the home of a relative or neighbor, arranging for the protective parent to leave a dangerous home

environment with the children, or having the alleged perpetrator leave the home. The parents and/or voluntary caregivers involved with ensuring child safety are asked to sign the safety plan and agree to the requirements and consequences of failing to abide by the plan. Departmental policy states that a safety plan ends at the end of an investigation, or, if the family is referred to Family-Based Safety Services, when services end and CPS determines it is safe for the child to return home.

**The Parental Child Safety Placement (PCSP)** is one type of arrangement used as part of a safety plan. The PCSP ensures safety by sending a child to live with a relative or other caregiver temporarily during an abuse or neglect investigation and/or family treatment. It is used as an alternative to removal that preserves safety while CPS investigates the case and assesses safety and risk. Specific DFPS policies regarding Parental Child Safety Placements are discussed in section, "Departmental Policy for PCSPs".

#### RISK ASSESSMENT

Within 45 days of intake, the CPS caseworker also completes a Risk Assessment, which determines whether there is a reasonable likelihood that children in the home will be abused or neglected in the foreseeable future after the investigation is closed. To make this determination, the CPS caseworker considers risk factors as well as family strengths and resources available to combat these risk factors and protect children. Prior abuse or neglect in the family is a key consideration in determining risk, as well as seven risk areas of concern, including child vulnerability, caregiver capability, quality of care, maltreatment pattern, home and social environment, caregiver's response to the intervention, and protective capacity (CPS Handbook §2235.2, §2235.3, and §2235.31-2235.38). After weighing the severity of risk in these areas versus a family's strengths in these areas, the CPS caseworker records a risk finding:

- **Risk Indicated:** If there are significant risk factors in the family's current situation or history and the family cannot manage the risk factors without CPS assistance (This indication is automatic if a child is removed from home during an investigation or if the family is referred to Family Based Safety Services). In 2009, 55% of all confirmed abuse and neglect cases received a "risk indicated" finding.
- **Risk Factors Controlled:** If there are significant risk factors in the family's current situation or history, but through the use of services, interventions, or resources other than CPS, the family is willing and capable of managing the risk and ensuring child safety over the next 12 months. In 2009, 45% of confirmed abuse and neglect cases received a "risk factors controlled" finding.
- **No Significant Risk Factors:** If there are no risk factors in the family's current situation or history that contribute significantly to the likelihood of abuse or neglect in the

foreseeable future. In 2009, <1% of confirmed abuse and neglect cases received a “no significant risk factors” finding.

- **Risk Assessment N/A:** In 2009, <1% of confirmed abuse and neglect cases received a “risk assessment N/A” finding (DFPS Databook, 2009).

Sometimes, a risk assessment is *not* completed, and the reasons are similar to those reasons a safety assessment is not completed: if the case is administratively closed, if the investigation is given the disposition Unable to Complete, if the investigation is school-related, or if the investigation involves a child who has died (DFPS, August 26). Also, a risk assessment may not be completed because the investigation was abbreviated and a safety plan was not needed during the investigation or because the family flees before a risk assessment can be completed (DFPS, August 26).

#### WHEN CHILDREN ARE AT RISK

If a CPS rules “risk indicated,” the CPS worker may proceed by referring a family to Family-Based Safety Services (FBSS) or seeking a court order to require a family to participate in FBSS. In 2009, 29,854 (or 97%) of all “risk-indicated” cases were opened for services (DFPS Databook: 36). If safety and risk are major concerns, the CPS caseworker consults with a supervisor to obtain approval to pursue a court removal. If a CPS caseworker determines that children in the home are not at risk, the worker refers the family to community services, if needed, and then closes the case.

The CPS Handbook (§2235.52) delineates specific actions that should be taken to control risk at the end of an investigation. These are presented in Table 1.

Table 1. CPS recommendations to control risk at the close of an investigation

If...	Then...
The child will not be safe from abuse or neglect over the next few days or weeks after the investigation...	The worker must recommend that the case be kept open, unless a court has ordered CPS to close the case.
The child will be safe for the next few days or weeks, but is not likely to be safe for up to the next three to 12 months...	The worker must recommend that the case be kept open and that services be offered to the family, unless a court has ordered CPS to close the case.
A court has ordered CPS to close the case...	The supervisor must immediately consult with the program director and the attorney handling the case to determine what action, if any, CPS can take to protect the children.
CPS offers services to the family and the family refuses services...	The worker and supervisor must consider obtaining legal intervention for court-ordered services or removal.

The family refuses CPS services and legal intervention is not possible or appropriate...	The supervisor must immediately consult with the program director to determine what action, if any, CPS can take to protect the child.
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TREATMENT

Once the CPS investigation team has completed the investigation and safety and risk assessments, a child victim may be living in a number of different situations. Some victims of abuse and neglect are formally removed from their homes during an investigation and placed in DFPS substitute care. These cases remain open and are handled by CPS conservatorship caseworkers. Other children may be temporarily placed with a relative or close family friend through a PCSP written agreement. Still others may have been permitted, based on the safety assessment, to remain at home with protective parents during FBSS or other community service treatment. During the investigation, cases in these last two groups are monitored by the CPS investigatory caseworker.

Cases in any of these arrangements may be selected for referral to **Family Based Safety Services** (FBSS) at the end of a CPS investigation, just as they may be subject to a removal if significant safety and risk concerns emerge. For children who are removed and placed in substitute care, the decision to refer the case to FBSS must be made by a judge. For children whose safety decisions are governed by a safety plan (those living in PCSPs or at home at the end of an investigation without court involvement), the safety plan may call for FBSS. In 2009, the average number of families participating in FBSS each month was 15,734. This charge focuses on the use of PCSPs by families during investigations and treatment phases *without court involvement*. In these cases, parents retain legal conservatorship and a court removal has not taken place.

The transfer of a CPS case from investigations to FBSS is governed by a loose time frame. First, there is no clear deadline to end an investigation. CPS policy allows the CPS investigation supervisor to extend the 30-day or 45-day investigation timeline if a case is referred to FBSS or substitute care/conservatorship. Second, without a court order, there is no clear deadline by which CPS investigations must complete the actual referral to FBSS. However, once the referral form has been submitted, the CPS investigation caseworker and supervisor must develop a new safety plan, assess family needs and staffing levels, and determine whether to open the case for services in FBSS within 10 days. That determination must be recorded electronically within 12 days. Once the FBSS case is documented, CPS must develop a **Family Service Plan**, indicating specific services to be undertaken by the family, within 21 days. This loosely-defined process could extend the period between the investigation and treatment phases for 43 days or longer after the investigation is technically complete.

For CPS cases that do not involve a removal and the courts, the FBSS treatment stage of a CPS abuse and neglect case involves families and children voluntarily working toward improving safety and protection by following the Family Service Plan and Child Service Plan. Each Family Service Plan is different. Examples of action items that might be found on a Family Service Plan include participating in CPS services, undertaking home repairs for the physical safety of a child, parent drug treatment, parenting classes, or homemaker services. DFPS estimates that the time required to complete a Family Service Plan can range from 3 to 9 months (Deckinga, May 13).

## DEPARTMENTAL POLICY FOR PCSPS

### FINDING PROSPECTIVE HOMES

The CPS Handbook S2234.4 states that it is best practice for the family to initiate a PCSP. CPS may intervene to initiate a PCSP if there is an emergency, if the placement is necessary to ensure child safety, or if the placement is necessary to prevent removal. CPS may also assist family members in making phone calls to relatives and providing transportation.

In 2007, DFPS began implementing a Family-Group Decisionmaking Model during the CPS investigation called the Family Team Meeting. Family Team Meetings are group meetings that occur prior to removal that invite family, relatives, friends, and other professionals to join together to develop a plan for immediate child care and protection in a CPS abuse or neglect case. DFPS attempts to make Family Team Meetings a part of all cases that involve an imminent removal or pending non-emergency removal, but they can also be used in other cases. A successful Family Team Meeting allows all in attendance to present information about the child's circumstances, needs, and available resources and forms a group consensus on a safe and caring placement for a child, whether that placement is in the child's own home, at a relative or friend's home, foster care, or another arrangement. CPS is not required to conduct a Family Team Meeting for all PCSP cases; however, a family may be referred to a Family Team Meeting when a PCSP is made for protective reasons, if the CPS caseworker would like to gather information to determine if the PCSP remains the best arrangement for the family.

In 2010, 8,026 Family Team Meetings were held and 1,093 follow-up meetings were planned as of June (DFPS, *SB 758 Implementation Progress Report*, September 1, 2010). In 2009, Family Team Meetings were held in 14.6% of confirmed investigations.

### SCREENING PROSPECTIVE HOMES

Current policy requires CPS to complete criminal background checks and abuse/neglect background checks on all adults in the prospective PCSP home (CPS Handbook §2234.43-

2234.44). A criminal history that includes any of the following may disqualify a prospective PCSP home, subject to the CPS worker's discretion:

- Criminal Solicitation of a Minor
- Offenses Against a Person
- Offenses Against the Family
- Robbery
- Failure to Stop or Report Aggravated Sexual Assault of a Child
- Stalking
- Public Indecency
- Felony convictions involving any of the aforementioned offenses

The safety check before a PCSP decision also involves a home assessment. In a home assessment, CPS visits the prospective PCSP home to assess the adequacy of the physical environment and to interview the prospective PCSP caregiver (CPS Handbook §2234.42). Currently, home assessments do not use standards for physical home safety to screen homes. However, all PCSP placements require CPS supervisory approval, and a supervisor can proceed with a placement without a safety check if the caseworker plans on completing the safety check within three days.

#### THE WRITTEN AGREEMENT

When a PCSP is made, it is recorded as part of a standardized state form, *Form 2604b Child Safety Evaluation and Plan: Plan for Immediate and Short-Term Child Safety*. The form is divided into three parts: Tasks and Services, Conclusion, and Signatures.

The largest section, Tasks and Services, provides space for the CPS worker to “[I]ist all tasks and services needed to provide for the child’s immediate and short-term safety.” The section consists of four identical blocks, one for each person involved in the case or caring for the child. The block has an open-response section for Family Task and CPS/Other Service related to that family member or caregiver, each with a Beginning and End Date (and/or Frequency) for that task. There is also a space for Method of Evaluation related to that family member’s commitment.

In the Conclusion section, the CPS caseworker provides an open response to the prompt, “Identify plans for further services. When appropriate, describe the potential consequences if the family does not carry out this plan successfully. If the case is to be closed, explain why.”

In the Signatures section, there are spaces for the signatures of two parents, the CPS worker, and the CPS supervisor. It also explains the meaning of the parent signature:

*By signing this form, the parents are agreeing to perform the tasks specified in this plan, and applying for Title IV-A emergency assistance to help cover the cost of CPS's services [...] Parents also agree that this plan does not conflict with any existing court order [...] The parents may request a review of this plan at any time. They may also request an administrative review or a fair hearing if CPS denies, reduces, or terminates any protective services or emergency assistance that they have requested, or does not act promptly on their request for services.*

#### TIME LIMITS

PCSPs are used during investigations and FBSS treatment stages. In investigations, a PCSP is documented as a safety plan that ends with the close of an investigation. If, at the end of an investigation, the child can return home safely with or without CPS involvement, policy states that the child should be reunited with family. If safety remains a concern and the legal criteria for removal is met, CPS should take conservatorship of the child. If a child still cannot be returned home safely but cannot be court-removed, policy requires the CPS caseworker to verify that the PCSP caregiver either has conservatorship or plans to obtain conservatorship before CPS can close an investigation.

If a family is participating in FBSS, PCSPs are also documented in the safety plan, but there is no policy that requires ending a PCSP before case closure. CPS policy states that an FBSS case can be closed if CPS services are no longer needed or for administrative reasons. CPS services are no longer needed if the family has reduced risk, the child is safe, and the family is capable of managing future risks. The administrative reasons for a closure include (1) a family moving *or* (2) if there is no legal basis for removal *and* either (a) the family refuses to accept further services or (b) CPS has already offered services for the designated need or CPS cannot provide or arrange the services needed. Cases in which family reunification is the goal may be referred from FBSS to Family Reunification Services and CPS involvement would continue.

The Committee has not found specific policies regarding ending a PCSP before an FBSS case closes (§3150). The only instruction provided for handling case closure for families in FBSS cases involving a PCSP is, "The case is not to be closed until the risk has been reduced or eliminated or other arrangements have been made" (CPS Handbook §3172).

#### DATA

It has been difficult to monitor the true impact of PCSP implementation on families because DFPS has only recently begun to collect data on their use. IMPACT, the data collection and case management system used by CPS, was enhanced in 2010 to begin tracking new PCSPs that occur in the investigation and FBSS stages. On June 6, 2010, DFPS began collecting information on:

- Number of PCSPs in Texas
- Number of children in PCSPs
- Relationship of the caregiver to each child placed in the PCSP
- When the PCSP is made and when it is closed
- The reasons for closing the PCSP
- PCSP status at the close of the investigation and FBSS

A report compiling information on PCSPs from June to December 2010 will be released in December 2010.

## POLICY ISSUES

### TIME LIMITS AND ENDING A PCSP

Currently, policy does not require CPS to specify an end date or a renewal date for a PCSP arrangement during investigations or FBSS. Rather, CPS recommends that workers continually assess the need for the placement based on whether or not it is safe for the child to return home. At the end of the investigation stage, policy directs staff to reassess safety and offers the following decision-making guidance (§ 2234.45):

- If the child can be safe living in the parent's home, with or without CPS involvement, reunite the child with the parents.
- If the child cannot be safely returned home or if the family's plan includes long-term care out of the home, verify the caregiver has conservatorship or plans to take conservatorship.
- If the legal criteria for removal are met and neither of the above options is feasible, remove the child and take conservatorship.
- It is not possible for CPS to take legal action, work with supervisor to determine how best to protect the child.

This guidance creates a loophole by which a CPS caseworker can close a CPS case without finding a permanent home for a child. In cases where a child cannot be returned safely home or requires long-term treatment, but when CPS has no grounds for removal, it is enough at the end of an investigation to verify that a caregiver "plans to take conservatorship" in order to close a case. If this happens, CPS closes without establishing legal boundaries for parents and caregivers or ensuring safety or placement permanency for the child.

Another area of concern emerges when a PCSP family is referred to FBSS. Assuming CPS makes a referral to FBSS at the completion of investigation tasks, loosely-defined CPS deadlines for ending an investigation and referring the case to FBSS could potentially add an additional waiting period of 43 days or longer wherein children placed in PCSPs must remain outside of

the home past the investigation stage. PCSP children whose families ultimately receive FBSS and/or Family Reunification Services after this referral process could remain in the PCSP for the additional 4 to 9 months more it takes for the parents to complete treatment.

Finally, it has been brought to the attention of the Committee and CPS that children are being left in PCSPs either after the closure of a case in the CPS investigation or FBSS/community services phases. While this undesirable arrangement at the end of CPS involvement may be, in part, due to caseworker errors, in some instances, it seems to be permitted in CPS policy records. For instance, a child can remain with the caregiver at the end of an investigation and the case is closed if a caregiver agrees to obtain conservatorship. Also, at the end of FBSS treatment, policy allows case closure if the CPS caseworker/supervisor finds that "risk has been reduced or eliminated," but does not specify whether risk reduction via PCSP placement is an acceptable interpretation. It is the Committee's belief that the extension of PCSPs beyond the life of a CPS case violates the intent of PCSPs.

The Committee feels that a failure to specify an end date for PCSPs results in placements that may increase risk and result in longer-than-intended PCSPs. The PCSP was designed to be a short-term living arrangement that ensured safety while the investigation was completed. The timeline for completing the investigation is within 30 days of intake, and supervisory approval of the investigation is completed within 60 days of intake. However, the timeline for completing an investigation is extended to 45 days when families – during or after the investigation – are referred to FBSS or placed in substitute care managed by CPS conservatorship (DFPS, June 15). Supervisors can further extend investigation time limits in certain situations, including when CPS has difficulty contacting the family or other relevant persons, when information critical to the investigation (e.g., from professionals or toxicology labs) is delayed, or when additional allegations of abuse or neglect surface (DFPS, June 15).

With investigations now lasting longer and with a substantial number of cases opened for services (28,837 in 2009), PCSPs can bind parents and caregivers to an indefinite time commitment extending over several months. In this context, it is critical that CPS improve its policies for PCSPs by better clarifying who is responsible for caring for a child during this time; what powers, rights and responsibilities caring for a child involves (e.g., education, health decisions); and how long to expect these changes to last.

#### SCREENING PROSPECTIVE PCSP HOMES

Current CPS policy does not clarify how to use information from background checks and home safety checks to screen prospective PCSP homes. As a result, the appropriate quality of prospective PCSP caregivers and homes is determined on a case-by-case basis by local CPS caseworkers. This policy allows for marked variation in living arrangements for PCSP children across the state. The Committee feels that CPS policy should be refined to guarantee a certain

standard of safety in prospective PCSP homes, especially in cases where PCSP arrangements extend over a period of several months.

#### PARENT ACCESS AND VISITATION

Current CPS policy does not require the caseworker to specify parent visitation arrangements in a PCSP, resulting in confusion among the parties involved. While parents retain legal rights to a child during the PCSP, another caregiver may be making many of the decisions in a child's day-to-day life. The Committee feels it is the responsibility of CPS to clearly state and document the rights and responsibilities of the parents, caregivers, and other interested parties regarding visitation during a PCSP.

Current CPS policy relies upon the PCSP caregiver to be willing and capable of setting appropriate boundaries to protect the child. CPS should regularly reevaluate the PCSP caregiver and home to ensure that the PCSP remains an appropriate method of protecting the child.

#### POWER OF ATTORNEY

Lengthy PCSPs make it difficult for parents and caregivers to make decisions regarding a child living outside of the home. In some cases, parents in substance abuse treatment may be unable to participate in enrolling their children in school or bringing their child to the doctor. In other cases, caregivers and parents may disagree about decisions regarding a child's health, education, and wellbeing; resulting in confusion about whom ultimately has decision-making rights.

Senate Bill 1598 (81R) called for the creation of an **Authorization Agreement for Nonparent Relatives**. The form was designed to make the process of transferring power of attorney for a child more accessible to the general public, especially low-income relatives informally caring for children and who cannot afford formal legal services. In Texas, 244,000 children are raised informally by relatives, and Senate Bill 1598 is targeted toward these families. According to Bruce Bower of Texas Legal Services Center, only a small share of these families have ever been involved in a CPS abuse and neglect case (May 13).

There is public concern that CPS caseworkers have begun incorporating the Authorization Agreement into the CPS process. Because the form was not designed for departmental use, the Committee feels that it is inappropriate for CPS caseworkers to use the Authorization Agreement, especially if it is presented in conjunction with other CPS documents designed to prevent court removals (e.g., Safety Plan, Parental Child Safety Placement).

#### RECENT ACTION TAKEN BY DFPS

DFPS has formed a monthly work group to study PCSP policy. The work group intends to finalize policy decisions by December 2010 after stakeholder review. DFPS reports that most of the following recommendations are congruent with ideas formed in the DFPS work group. Major differences are highlighted, when applicable, in the recommendations list below.

## RECOMMENDATIONS

- **Prevent the closure of a CPS case when a child remains in the PCSP placement.** One way to prevent the closure of a CPS case when a child remains in a PCSP is to block the closure of a PCSP without legal rights established. This policy may extend the life of a CPS case and will likely command more state resources, but the Committee feels this may be necessary to guarantee safety, stability, and permanency for the child after CPS involvement ends. For example, this new policy may require CPS to assist relatives in obtaining legal custody if a child cannot return safely home, to reunify and monitor child safety at home, or to seek a removal if safety cannot be achieved. DFPS notes that because the PCSP is initiated by the parent, in some cases, the parent may allow the child to remain in the placement after the CPS case is closed. The agency feels placement in these types of informal arrangements may be necessary in instances where a child has no other viable alternative that would provide safety. Examples include cases where a child is in a PCSP and the parents disappear during the case and cannot be located; or a parent is incarcerated and makes a decision to leave a child with a PCSP caregiver. The Committee feels that any permanent arrangement that allows an informal caregiver to remain as a protective placement while a parent retains conservatorship must meet a high standard that guarantees child safety and risk mitigation after CPS involvement ends. If a child cannot return safely home after a CPS case ends, but it is possible that a child *may* return home without CPS supervision, it is inappropriate for CPS to close the case.
- **Establish a PCSP start and end date or schedule regular discussions in which agency, parents, and caregivers are allowed to renew or revoke the PCSP placement.** The Committee recognizes that a definite PCSP start or end date may not be appropriate for all cases. One example is when children are cared for by relatives while their parents are undergoing drug treatment recommended in the safety plan. If it is impossible to establish a definite PCSP start and end date, the Committee believes that CPS should facilitate discussion that allows all parties involved - CPS, parents, and relatives - to

renew or terminate a PCSP voluntarily. One possible scenario would require all parties involved to renew or revoke the PCSPs every 60 days the PCSP remains open.

- **Create a standardized PCSP form.** The form should prompt the CPS caseworker to identify a specific PCSP start and end date *or* a renewal/reevaluation date and parent/caregiver visitation rights and responsibilities for that period of time. These items would supplement the parent/caregiver safety tasks and requirements that are already part of the PCSP written agreement.
- **Specify how background check information should be used to screen PCSP homes.** The Committee believes that PCSP policy should specify the time period for which minor offenses remain “relevant” for the purposes of screening PCSP homes and which offenses or felonies automatically rule-out vs. minor offenses that caseworkers can evaluate on a case-by-case basis. DFPS reports that currently, background information for potential PCSP homes is screened using the same guidelines that apply to Kinship placements (CPS Handbook §6322.33). This policy is being reviewed to incorporate CCL criminal history regulations approved in October 2010. PCSP background screening will not be more restrictive than CCL screening guidelines.
- **Establish safety guidelines for potential PCSP homes.** Currently, CPS policy states that a PCSP home must be safe with no specific guidelines for the worker who must make the initial assessment.

## TESTIMONY AND PUBLIC COMMENT

The House Committee on Human Services heard testimony on Charge 2 on May 13, 2010 at the Texas State Capitol in Austin. Testimony was provided by Child Protective Services, stakeholder groups, and the public at large. This section summarizes public and written testimony received by the committee related to the use of Parental Child Safety Placements during child abuse and neglect investigations and Family Based Safety Services.

### 1. AUDREY DECKINGA, CHILD PROTECTIVE SERVICES

On May 13, Audrey Deckinga, Assistant Commissioner for Child Protective Services, provided written and public testimony on departmental PCSP policy, new developments and future plans for PCSPs, and information on the Authorization Agreement for Nonparent Relatives.

Ms. Deckinga explained that PCSPs are used during both the investigation and FBSS phases, if reasonable efforts have been made to reduce the risk of abuse without removing the child from his/her home. The PCSP is intended to be a temporary and short-term placement that allows CPS to evaluate risk and to implement safety measures in the child's home. It has specific benefits over foster care in the early stages of a CPS case, as it preserves child safety while providing continuity in the child's environment (e.g., relationships, schools, healthcare) and avoiding placements in foster care. Ms. Deckinga emphasized that CPS does not make or select placements. However, it does perform background checks on parent-referred placement options. If the parent-referred placement passes all background checks and the home passes the safety assessment, it can be approved to become a PCSP.

Ms. Deckinga distinguished between a PCSP and kinship care and discussed appropriate and inappropriate uses of PCSPs. She clarified that PCSPs should not be given an open-ended time frame. Also, PCSP caregivers should be willing to care for a child, have sufficient resources to care for a child, be capable of understanding and complying with the safety plan, and be cooperative with CPS services. All PCSPs should be ended prior to the closure of a CPS case. Inappropriate use of PCSPs result in a child's permanent displacement in a relatives' home with no payment to that relative and no transfer of conservatorship in court. CPS acknowledges that inappropriate uses of PCSPs can result in tenuous living arrangements that do not meet CPS' standard of protection and child safety.

Ms. Deckinga reported several new developments at CPS regarding PCSPs. The department launched a PCSP workgroup in May 2009, recognizing the need to review PCSP policies and procedures. The workgroup continues to meet to address needed improvements to PCSPs, to develop policy to guide staff in making PCSPs, and to develop a data tracking system for PCSPs. Input from other CPS initiatives has also informed CPS of ways to improve PCSPs, including CPS' statewide Parent Collaboration Group and regional FBSS and investigation case reviews. Also, as instructed by Senate Bill 1598 (81 R), CPS has developed and posted the Authorization Agreement for Nonparent Relative form publically at the DFPS and TEA websites. CPS began collecting PCSP data in June 2010 and plans to train front line caseworkers in PCSP use and to improve communication between CPS and the PCSP caregiver.

## 2. JANE BURSTAIN, CENTER FOR PUBLIC POLICY PRIORITIES

On May 13, Jane Burstain, Senior Policy Analyst with the Center for Public Policy Priorities, provided public and written testimony related to four areas for which PCSPs lacked policy guidance: caregiver assessments, rights and responsibilities, ending a placement, and closing a case during a placement.

According to Ms. Burstain, without policy clarification, caseworkers may have trouble conducting caregiver assessments consistently and uniformly throughout the state. Her analysis of policy in the CPS Manual revealed that CPS offers no guidance on how the assessment of potential PCSP homes should be performed, how to assess certain criminal offenses that may appear on a prospective caregiver's criminal background check (for example, substance abuse or old criminal convictions), or how to discern what home safety features are acceptable for a PCSP. Ms. Burstain recommends that CPS develop a separate assessment instrument to document assessment steps and to include that documentation as part of the written case file. Also, if a potential PCSP caregiver is rejected, Ms. Burstain recommends that DFPS require the caseworker to discuss with the parent the reasons DFPS believes the placement is not safe so that the parent can clarify any misunderstanding, offer a solution, or find an alternative placement.

CPS policy does not require that a safety plan include a plan for parental visitation or a plan for obtaining services for the child. Ms. Burstain noted that omitting visitation and service planning for the child in a safety plan results in confusion regarding the rights and responsibilities of the parent and caregiver during a PCSP. To clarify parent and caregiver rights and responsibilities, Ms. Burstain recommended that all safety plans include a written plan of how often and under what circumstances a parent can visit a child as well as a plan for how the caregiver will obtain necessary services for the child, including medical treatment and school enrollment. Ms. Burstain suggests that DFPS incorporate the "Authorization Agreement for Nonparent Relative" form made available by Senate Bill 1598 (81R), which is a written agreement between parents and a relative caregivers that grants the relative caregivers power of attorney for a child. A version of the form can be found at [http://www.dfps.state.tx.us/documents/Child\\_Protection/2638.pdf](http://www.dfps.state.tx.us/documents/Child_Protection/2638.pdf).

CPS provides general guidelines for how long PCSPs should last, but CPS policy does not require a specific ending date for a PCSP. Ms. Burstain reported that this practice can lead to longer-than-intended PCSPs and misunderstandings among CPS, the parent, and the PCSP caregiver. A recommended solution is to include a specific ending date for each PCSP. On this date, the CPS caseworker should evaluate if any changes need to be made and either renew or revise the PCSP and obtain new parent and relative signatures.

Current policy states that PCSPs must end at the end of an investigation unless the case is referred to Family Based Safety Services. However, Ms. Burstain noted that CPS policy does not define what constitutes the end of an investigation, resulting in longer than necessary PCSPs during the investigation stage. She recommends that DFPS amend policy to identify a specific action that ends an investigation, and thus, defines the end of a PCSP. To reduce the duration

of PCSPs for cases that are referred to FBSS, Ms. Burstain recommends setting a deadline by which investigations should make referrals to FBSS.

Ms. Burstain also recommends preventing the closing of a CPS case while the child is still in a PCSP. This may happen if the PCSP caregiver agrees to pursue conservatorship of the child and CPS determines that the child cannot return safely home. If a child remains with a PCSP caregiver without transfer of conservatorship and CPS closes the case, it is possible for a parent to take the child back to an unsafe home. Lack of conservatorship leaves the PCSP caregiver with no legal recourse. To close the loophole, Ms. Burstain recommends that CPS - before the closure of a case - record either that the PCSP caregiver has either obtained conservatorship or a written plan with deadlines for obtaining conservatorship.

Ms. Burstain's full written testimony can be accessed at [http://www.cppp.org/files/4/10\\_05\\_janetestimony.pdf](http://www.cppp.org/files/4/10_05_janetestimony.pdf).

### 3. JUDY POWELL, PARENT GUIDANCE CENTER

On May 13, Judy Powell, Communications Director with the Parent Guidance Center, provided public and written testimony expressing concern over potential misuses of Parental Child Safety Placements and the Authorization Agreement for Nonparent Relative form and offering recommendations. Ms. Powell testified that the Authorization Agreement for Nonparent Relative form, used in tandem with a CPS PCSP, can be used to coerce parents to forfeit their decision-making powers under the threat of removal when it is not necessary to do so to prevent removal. Ms. Powell further testified that a lack of a state policy standard for time limits or visitation arrangements in a PCSP violates the Fourth Amendment against unreasonable searches and seizures, as parents and children are uncertain whether they are free to reunite in the child's home at the end of CPS investigations and treatment services. Ms. Powell sees PCSPs as an "off-books" removal that is contrary to the spirit of the federal Adoption and Safe Families Act's "reasonable efforts" clause, which requires that reasonable efforts be made to preserve and reunify families before removing a child from his or her home (Public Law 105-89). Ms. Powell testifies that PCSPs can be traumatic experiences for children and that they should not be used if there is not an emergency in the home.

Ms. Powell said the Authorization Agreement for Nonparent Relatives was intended to be used as a tool for specific, long-term family caregiving arrangements. Because CPS investigations should last a period of days or weeks - rather than months or years - Ms. Powell feels it is not appropriate to use new Authorization Agreements during the CPS investigation stage. Ms. Powell also feels that because parents have no legal counsel during the CPS investigation, they may not fully understand how signing (or not signing) a PCSP or Authorization Agreement for Nonparent Relative form may affect their CPS case.

Based on her experience working with parents, Ms. Powell recommends the following to DFPS:

- Establish a clear process for PCSPs.
- Provide parents and relatives access to an attorney if considering a Power of Attorney change.
- Use the Power of Attorney change only in specific circumstances during long-term service delivery to parents (e.g., inpatient drug treatment). Do not use the Power of Attorney change in cases without emergency or exigent circumstances.
- Prohibit DFPS retaliations and sanctions if a parent does not agree with a placement.
- Provide a clear revocation process with a chain of enforcement if prospective caregivers do not cooperate.
- Provide clear visitation and contact instructions to parents, family members, and the CPS caseworker during the PCSP.
- End a PCSP on a specific date; prohibit indefinite extensions.
- Establish time limits for investigations.
- Create a grievance process to address misunderstandings during PCSPs.
- Make reasonable efforts to preserve the family.

#### 4. BRUCE BOWER, TEXAS LEGAL SERVICES CENTER

On May 13, Bruce Bower of the Texas Legal Services Center provided public testimony describing the history of Senate Bill 1598 (81 R) and the purpose of the Authorization Agreement for Nonparent Relative form. Mr. Bower explains that the Authorization Agreement was designed for relatives caring informally for 244,000 children in Texas. The Authorization Agreement does not transfer parental rights, but it does allow signees to keep decision-making in the family. Mr. Bower testified that the Authorization Agreement envisioned by the lawmakers who passed SB 1598 in June 2009 was one that would demystify the law and make it accessible to the general public. It was expected that making the form available publically would greatly benefit parents and relative caregivers who were poor and could not afford to hire legal counsel to transfer power of attorney concerning a child. In this context, the form was designed particularly with relatives caring for children in mind. The Authorization Agreement was not intended to be a departmental form.

Mr. Bower provided a sample of the agreement form (See Appendix) and described it to the Committee.

#### 5. OTHER PUBLIC TESTIMONY

Dianna Martinez of the Texas Association for the Protection of Children provided public testimony on May 13, 2010. She reported that 244,100 children in Texas are living without

their biological parents who could benefit from the Authorization Agreement for Nonparent Relatives. She recommends that the form be posted in other public places to improve access (e.g., the TEA website) and that a new component be added to Authorization Agreement that identifies a termination date that revokes the transfer of rights to relatives.

Elaine Carter, a child welfare practitioner with Casey Family Programs, provided public testimony on May 13, 2010. Ms. Carter reported that in Texas, removal rates are low, and kinship care is prevalent. Still, the level of services and resources available to kinship caregivers remains low. She identifies a latent risk in the current child welfare system where the duties of the child welfare system to protect children is transferred to kinship caregivers. She said that kin supervision of visits with parents is one example of a responsibility kinship caregivers are asked to assume. Ms. Carter reports that only parents are entitled to services such as food stamps, emergency assistance payment, and other benefits, even while kinship caregivers are providing critical care and protection for abused or neglected children. Permanent placement plans are uncertain for all involved. Ms. Carter is concerned that without legal action that establishes kin conservatorship, parents can take children back from kin at will. She is also concerned that kin caregivers face considerable barriers to obtaining legal assistance that would enable them to secure conservatorship of a child in court.

Deana Garza, a mother who became involved in a CPS child abuse and neglect case, provided public testimony on May 13, 2010. Ms. Garza expressed that she felt her experience with the CPS system was a struggle. Now that the case has ended, she feels her children have poor outcomes, including living arrangements that separate of siblings and siblings acting out because of placement instability and being away from home. Ms. Garza recommends developing more support for parents who are abusive to stop the cycle.

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## CHARGE 6

*Monitor the agencies and programs under the committee's jurisdiction.*

*1. The nursing facility backlog.*

According to DADS Commissioner Chris Traylor's interim hearing testimony and follow-up correspondence with DADS staff in November, the backlog has been completely remedied and no further issues exist at this time.

*2. Recent findings of abuse & neglect in Texas' residential treatment centers.*

### EXECUTIVE SUMMARY

Residential Treatment Centers (RTCs) provide intensive, 24-hour therapeutic treatment for clients with emotional and behavioral concerns that prevent them from properly integrating into society. According to the American Association of Children's Residential Centers, "[Child r]esidential programs are designed to assess and stabilize children so that families can be reunited as quickly as possible, given the needs of the child and family" (2010). To do so, RTCs provide families with:

- A restricted living environment for children,
- 24-hour direct care by trained staff,
- Regular therapeutic treatment with specialists, and
- Educational and child development activities.

In Texas, RTCs are regulated to ensure safety and quality of care. All RTCs that exclusively provide care and treatment services for children aged 18 or younger and that serve more than 12 children must meet the state's Residential Child Care Licensing (RCCL) Minimum Standards for General Residential Operations ([http://www.dfps.state.tx.us/Child\\_Care/Child\\_Care\\_Standards\\_and\\_Regulations/default.asp#Residential\\_Agencies](http://www.dfps.state.tx.us/Child_Care/Child_Care_Standards_and_Regulations/default.asp#Residential_Agencies)) . Currently, 80 RTCs are licensed and operating in the state of Texas representing a licensed capacity of 3,630 beds. Sixty-six of these are contracted by the state to care for 1,583 children in DFPS conservatorship. Half of RTCs contracted by the state are located in the Houston area.

The subject of this charge is Daystar Residential, Inc., an RTC that has been approved by Texas RCCL since 1995 to care for children who struggle with significant behavioral and mental health needs. Daystar has become the subject of much public concern after multiple reports of alleged and/or confirmed instances of abuse and neglect over the past several years. Enhanced monitoring efforts by DFPS since June 2010 revealed additional managerial concerns

regarding the excessive use of physical constraints and medication, no individualized treatment plans for its children, and the lack of management processes supporting internal monitoring and process improvement to correct these concerns. Shortly after DFPS monitoring ended, on November 5, 2010, a 16-year-old youth died after staff applied physical constraints. DFPS began reassessing the placements of all CPS children at Daystar before this incident, beginning on November 1, when the facility was placed on probation by DFPS. However, the facility remains an option for private care of young Texans and other children sent there from throughout the United States. The Committee recommends an intensive inquiry into how RCCL applies corrective action in cases where RTCs have been cited with multiple allegations and confirmed instances of abuse and neglect and minimum standard deficiencies. To preserve safety for some of Texas' most vulnerable children, we feel this situation deserves careful and deliberate consideration. A decision about the appropriateness of continuing Daystar's residential operating license in the state of Texas should consider the priority of protecting children.

#### HEIGHTENED PUBLIC CONCERN: ABUSE AND NEGLECT AT RTCs

Texas RTC operators came under increased public scrutiny after *The Texas Tribune* and the *Houston Chronicle* published stories recounting a 2008 incident at Daystar Residential, Inc. in Manvel, Texas in which two direct care staff members encouraged adolescent girls to fight. More recently, distressing news of a youth death at Daystar Residential, Inc. on November 5 after staff applied emergency physical restraint raises grave concern about the quality of care for children at this facility.

Daystar Residential, Inc. has been licensed in Texas since 1995 to treat children with emotional disorders, mental retardation, and pervasive developmental disorders. As of July 2010, it was serving roughly 50 children in the care of Texas Child Protective Services (CPS) and 20 non-CPS children divided among TYC, county juvenile probation, and mental health care transfers from California. Ownership reported that most residents of Daystar are mental health diagnosis, and roughly 35 percent are dual diagnosis (Salls, July 9).

On April 24, 2008, a group of seven female Daystar residents under the conservatorship of CPS aged 12-17 were injured in a fight that occurred under the supervision of two direct care employees. Injuries were noticed by a health worker and reported to DFPS intake on April 25. DFPS child abuse and neglect investigations ruled that the girls were encouraged to fight, and a medical assessment found that four children were injured. Daystar terminated contracts with the employees, and DFPS ruled Reason to Believe on 12 counts of abuse (6) or neglect (6) for each staff member. RCCL cited four deficiencies related to state minimum standards related to employee general responsibilities, children's rights, and caregiver responsibility.

On November 5, 2010, 16-year-old Daystar resident Michael Keith Owens died after the application of restraint at Daystar. This case was still under investigation at the time this report was completed.

## DFPS RESPONSE TO HEIGHTENED PUBLIC CONCERN

In response to heightened concerns regarding incidents at Daystar and other Texas child RTCs, DFPS has taken several actions that affect all state RTCs and additional measures affect Daystar specifically.

### IMMEDIATE ACTIONS AFFECTING REGULATION OF ALL RTCs

- Enforcement team conferences were conducted in June and July 2010 at all RTCs (DFPS, June 22).
- RCCL adopted new policy to follow-up on any findings of abuse/neglect and any serious deficiencies with an unannounced inspection within 30 days of the initial finding or citation (DFPS, June 22).
- RCCL created and implemented more rigorous protocols for RTC staff interviews and child interviews to be used during all team and follow-up inspections (DFPS, June 22).
- DFPS reviewed its system of notifying law enforcement of reports of abuse or neglect, with a specific focus on making communications with law enforcement more efficient and automatically storing message logs. By July 15, DFPS had created a new system to retrieve fax confirmations and store them in the DFPS case management database. On August 1, DFPS statewide intake began contacting all law enforcement agencies to encourage them to convert to a more efficient system of notification using a permanent, generic email address (Heiligenstein, June 30).
- RCCL asked the National Association for Regulatory Administration to review its processes for childcare licensing; DFPS used findings to inform recommendations for revisions to state minimum standards in September 2010 (DFPS, June 22; Heiligenstein, June 30).
- In July 2010, Commissioner Suehs transferred 11 licensing staff from DADS to DFPS to increase RTC oversight in Region 6: Houston (DFPS, July 15).

### ACTIONS AT DAYSTAR RTC

- RCCL conducted unannounced night and weekend visits to Daystar in June 2010 (DFPS, June 22).
- CPS halted all new child placements at Daystar on June 11, 2010. From June 22 to August 18, the census of CPS children remaining in care at Daystar fell from 55 to 46. DFPS completed safety checks and safety assessments for each child at Daystar,

considering whether other placements may be more suitable on a case-by-case basis (DFPS, June 22; DFPS, August 18).

- DFPS hired a monitor to evaluate safety, risk, and treatment practices used at Daystar. The assignment, which lasted from June 22 to August 31, 2010, resulted in three monitoring reports, which are discussed in the next section.
- A cross program team from RCCL and CPS conducted an inspection of the Daystar facility in July 2010. The inspection team reviewed child and employee records, interviewed children and staff, and reviewed Daystar policies and curriculum. The contract team reviewed child records, the quality of service delivery, and compliance with contract, program, and legal requirements. The licensing team monitored for compliance with RCCL minimum standards. Daystar received eight citations for minimum standards deficiencies related to medication administration and related training, service planning for children, and operation evaluations. The contract team issued 19 citations related to behavioral and health inspection findings. Daystar was asked to submit a corrective action plan (DFPS, August 18).
- On November 1, 2010, RCCL placed Daystar on probation for repeat deficiencies. DFPS established plans for each CPS child to move to another facility.

#### FINDINGS FROM THE MONITOR'S REPORTS

The monitor's reports concerning Daystar Residential, Inc. were released July 9, 2010, August 2, 2010, and September 1, 2010 (Enzinna, 2010 (a),(b),(c)). These reports detail the monitor's information-collecting activities at Daystar, findings, and recommendations. The monitor describes his impressions of Daystar Residential, Inc.'s strengths and challenges after collecting information from staff, agency records, and community sources. The monitor found that the facility benefitted from experienced staff that expressed care and concern for clients and had succeeded in reducing the service level needs of a large majority of its clients (94% experienced a reduction of at least one service level). Within this context, the monitor observed several serious challenges:

- Overreliance on emergency physical constraints and emergency medication, where milder interventions might have been effective.
- Overreliance on behavioral management rather than behavioral treatment, and lack of training on behavioral treatment.
- Evidence that all clients have the same behavioral treatment plan, and no client had an individualized behavioral treatment plan.
- Lack of structured play outside of the home for children. Children were rarely engaged during leisure time.

- While data collection and reporting is performed on site, management rarely uses the data to improve treatment practices. For example, there are no systems in place to evaluate the program's use of emergency physical constraints, medication errors, and/or staff performance.

#### CONTEXT: RECENT LEGISLATION AND POLICY CHANGES AFFECTING RTCs

Even before these actions had taken place, enrolled legislation heard in this Committee and RCCL minimum standards revisions had begun to strengthen the regulation of child RTC operators in Texas.

As part of the first wave of CPS reforms, **Senate Bill 6 (79R)** raised minimum qualifications for Licensed Child Care Administrators, required RTC operators to self-report serious incidents of abuse or neglect, increased background check requirements for RTC employees, required initial and ongoing drug testing for RTC employees, and required RTC operators to conduct emergency behavior training (Heiligenstein, June 30).

**Senate Bill 758 (80R)** further modified residential licensing and minimum standards practices and raised the payment rate for residential care providers by 4.3%. It created a new Committee on Licensing Standards with membership appointed by the governor, required licensing team inspections, and doubled the agency's licensing staff (Heiligenstein, June 30).

In January 2007, DFPS enacted new minimum standards for RTCs that reduced child-to-staff ratio requirements from 8:1 to 5:1, raised the caregiver age requirement from 18 to 21, raised the minimum qualifications for an operator's Treatment Director, and increased training requirements for caregivers and professional staff.

DFPS announced another major revision to RCCL Minimum Standards on September 1, 2010. The following selected Minimum Standards requirements will impact RTC operations in the future:

- Must operate as if 100% of their children receive emotional disorder treatment services.
- Must document and assess high-risk behaviors when a child is admitted and document actions related to each risk behavior in the child's safety plan (Minimum Standards 748.43, 748.1205, 748.1271, 749.43, 749.1107, 749.1189).
- Require staff, caregivers, and foster parents to report suspected abuse, neglect, or exploitation directly to DFPS; internal administrative reports will no longer be sufficient for DFPS investigatory purposes (748.105 and 749.105).

#### EMERGING POLICY ISSUES CONCERNING CHILD RTCs

In the past two years, there have been 250 confirmed instances of abuse, neglect, and maltreatment at RTCs in Texas (Ramshaw, 2010). Because these facilities treat a small share of foster children with specialized needs, and because a number of RTCs (like Daystar) are located in secluded areas removed from commerce, caseworkers, and friends and family, major risks may be overlooked. DFPS reports that Senate Bill 6's requirement that RTCs self-report alleged abuse and neglect has increased RCCL and DFPS investigations at RTCs. However, the Committee was unable to collect information at the time of this report's publication to answer some important questions regarding how DFPS uses findings of abuse and neglect and violations of minimum standards to impose corrective action or how corrective actions have been historically applied in the state of Texas.

Table 1 presents the top ten RTC deficiencies in Texas found from January 1, 2008 through May 31, 2009.

**Table 1. Top Ten RTC Deficiencies, January 1, 2008 to May 31, 2009**

<b>Standard Rule</b>	<b>Description</b>	<b>Deficiencies</b>	<b>Rank</b>
748.3301(a)	<b>Physical Site</b> -Buildings must be structurally sound, clean, and in good repair. Paints must be lead-free.	88	1
748.507(1)	<b>Employee general responsibilities</b> -Demonstrate competency, prudent judgment, self-control in presence of children and when performing assigned tasks.	65	2
748.685(a)(4)	<b>Caregiver responsibility</b> - providing the level of supervision necessary to ensure each child's safety and well-being.	65	2
748.3391(a)	<b>Bathrooms</b> -Must be maintained in good repair & kept clean.	50	4
748.2151(a)(8)	<b>Medication Record</b> -Must include accurate running count of each prescribed medication.	47	5
748.3301(i)	<b>Physical Site</b> -Equipment and furniture must be safe for children and must be kept clean and in good repair.	41	6
748.3365(a)(3)	<b>Bedding</b> -Must provide each child with a mattress cover or protector or mattress that is waterproof or washable.	28	7
745.625(a)(7)	<b>Background checks submitted</b> -every 24 months after first submitted.	26	8
745.4151(c)(4)(A)	<b>Mandatory drug testing</b> -all applicants intended to be hired are subject to pre-employment testing, must have results prior to child access.	25	9
748.3301(c)	<b>Physical Site</b> -Windows & doors must be in good	25	9

	repair & free of broken glass or hazards.		
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DFPS reports that it faces challenges balancing the need to support sufficient capacity while reducing risk and ensuring safety. On June 30, Commissioner Heiligenstein's presentation noted, "As recently as 2007, CPS faced significant capacity challenges [...The n]umber of foster children grew faster than the number of placements available. Increases in both regulation and enforcement at residential facilities resulted in RTCs being reluctant or unwilling to admit children with high-risk behaviors. The increase of serious incidents and resulting investigations created liability concerns for RTCs. As a result, children were spending nights in DFPS offices or other locations." A November 1 DFPS memo provides additional information on RTC challenges from DFPS' perspective.

RCCL currently faces multiple challenges related to investigations. First, with Senate Bill 6 requiring residential child care providers to self-report significantly more serious incidents, investigations for RCCL have risen accordingly. Although all incidents required to be self-reported directly relate to the health and safety of children in care, many of these investigations result in no finding of abuse or neglect and no finding of a standards violation related to the incident. Therefore, RCCL is challenged to continue responding to these reports and ensuring the health and safety of children, while also attempting to make the best use of RCCL staff time in conducting inspections and investigations.

The most challenging of the self-reports are injuries related to physical restraints. While the injuries are typically minor, RCCL consistently struggles with facilities and caregivers who use restraint as discipline and/or as a method to control children's behavior, rather than as a true crisis management tool. RCCL staff frequently investigate restraint-related injuries that resulted from a restraint that simply was not necessary. While RCCL has specific minimum standards related to de-escalation, minimal force, and not using restraint as a discipline method, enforcing these largely clinical concepts can be a challenge. This is particularly true for Licensing staff who have no prior work experience with emotionally disturbed children.

Using restraints as an example of the challenge between regulation and ensuring capacity at residential treatment centers so children can be treated, there are inherent challenges when Licensing wants the use of restraints to be reduced, medical providers want the use of psychotropic medications reduced but at the same time regulatory requirements increase and the facility is held responsible for restraint-related injuries or conversely, for behavior that doesn't change or improve as a result of the facility's intervention. With Licensing having a lower tolerance approach related to restraints (in an effort to better ensure restraints are used only as a true crisis management tool), there is an related impact to providers who've indicated that the reimbursement rates do not promote the hiring and retaining of higher quality staff and caregivers with more therapeutic skills, knowledge and education that would likely reduce the use of restraints.

Balancing regulatory expectations and enforcement actions with Child Protective Services' need for placements remains challenging. Child Protective Services (CPS) is the largest consumer of services regulated by RCCL, and residential child care providers consistently express concern that they cannot provide adequate care based on the HHSC reimbursement rates. Although many fund-raise to fill the gap,

this is becoming more difficult in the current economy. The struggle to adequately fund their programs can result in residential child care providers only able to do the minimum; unable to offer the higher quality or innovations that CPS and all parents would hope and expect for their children in care. (DFPS, November 1).

Current reimbursement rates for 24 hour care facilities are included below in Table 2.

**Table 2. 24-Hour Residential Child Care Rates in Texas**

Service Level	Type of Care	FY 2010-2011
<b>Basic</b>	Child Placing Agency	\$39.52
	Foster Family	\$22.15
	Residential Treatment Facility	\$42.18
<b>Moderate</b>	Child Placing Agency	\$71.91
	Foster Family	\$38.77
	Residential Treatment Facility	\$96.17
<b>Specialized</b>	Child Placing Agency	\$95.79
	Foster Family	\$49.85
	Residential Treatment Facility	\$138.25
<b>Intense</b>	Child Placing Agency	\$175.66
	Intense Foster Family	\$88.62
	Intense Residential Treatment Facility	\$242.85
	Emergency Shelter	\$115.44
	Intensive Psychiatric Transition Program	\$374.33

Note: The Texas Health and Human Services Commission (HHSC) developed the following payment rates for the 24-Hour Residential Child Care (Foster Care) program operated by the Department of Family and Protective Services (DFPS). HHSC authorized DFPS to implement these recommended payment rates effective September 1, 2009. Source: [http://www.dfps.state.tx.us/PCS/rates\\_childcare\\_reimbursement.asp](http://www.dfps.state.tx.us/PCS/rates_childcare_reimbursement.asp).

## RECOMMENDATIONS FOR IMPROVING OVERSIGHT OF RTCs

Improving the standard of care at state RTCs requires a better understanding of how RCCL addresses sites with multiple minimum standards deficiencies. To address ongoing concerns at Daystar, and to improve oversight of RTCs generally, the Committee recommends:

- **Complete the process of relocating all CPS children currently residing at Daystar and reevaluate its residential operating license.**
- **Instituting more rigorous background checks for all RTC employees.** Revise state minimum standards to require that the operator obtain FBI background checks for all RTC staff. Improve and strengthen DFPS' risk evaluations for potential employees with minor offense criminal histories.
- **Investigating the use of corrective action by RCCL.** The Committee recommends further investigation of the use of corrective action by RCCL, especially in cases concerning RTCs cited for multiple deficiencies. The investigation should address how deficiency patterns are monitored by RCCL, the circumstances underlying past applications of corrective action, and the extent to which the use of different forms of corrective action affects quality of care, risk factors for abuse and neglect, and state placement capacity.
- **Analyze variations in RTC funding structures and how funding structures and resource levels relate to firm behaviors (e.g., personnel hiring decisions) and risk outcomes.**

## HEARING TESTIMONY

### ANNE HEILIGENSTEIN, COMMISSIONER OF DFPS

Commissioner Heiligenstein provided written and public testimony to the Committee on June 30, 2010. The Commissioner provided a historical perspective of RTC operations in the state of Texas, a review of how DFPS reforms in 2005 and 2007 has affected RTC operations, and current challenges and potential solutions regarding RTCs. As recently as 2007, CPS faced significant placement challenges, as the number of foster children grew faster than the number of placements available. Increases in regulation and enforcement at RTCs affected RTC operators' intake decisions, with many refusing to admit children with high-risk behaviors due to liability concerns. As a result, many of these high-risk children had no place to go.

Part of Commissioner Heligenstein's effort to reform foster care involves citing more RTCs near the residential origins of children to allow for greater oversight by RCCL, families, staff, and CPS caseworkers assigned to RTC-placed children. Commissioner Heligenstein also outlined how recent changes to minimum standards, enhanced oversight at all RTCs provide a safety solution, and improvements in the system of communications between law enforcement and DFPS may

help to address risk concerns at RTCs. Commissioner Heiligenstein detailed the actions that DFPS had taken at Daystar as of June 30:

- CPS workers conducted safety checks on all CPS children and continue to have an increased presence at the facility.
- Standard by standard inspections.
- Deployed RCCL resources from other regions to support intensive monitoring effort.
- Significantly increased unannounced and team inspections, including evenings and weekends.

Commissioner Heiligenstein also outlined the elements of Daystar's Safety Plan:

- CPS placements at Daystar have been suspended.
- Safety checks were performed on all children at Daystar.
- DFPS contracted with an on-site monitor at Daystar.
- Star Health asked to provide trauma-informed training for Daystar staff.

#### MIKE FOSTER, TEXAS ASSOCIATION OF CHILD PLACING AGENCIES

Mr. Foster provided written and public testimony to the Committee on June 30, 2010. Mr. Foster explained that children in residential treatment suffer serious emotional, psychological, behavioral, and social difficulties that make it difficult for them to live in a family, attend school, or to thrive in community life. Frequently, children who come into the care of an RTC have already experienced substantial placement instability and are likely to experience continued placement instability after leaving an RTC. Mr. Foster believes that creating permanency for these high-risk children will require better assessment, triage, and service delivery. He envisions an effective system as one with an automatic trigger at the first displacement of a child that results into an RTC. The trigger involves a "SWAT" team (Services Working All Together) that would work to prevent future disruptions by developing long-term solutions for the child. The SWAT team would begin early by helping the family complete health assessments, triage, concurrent and holistic family-centered case management, wrap-around services, and deliberate transitions through the continuum of care. He believes care should be continuous, uninterrupted by multiple discharges now occurring due to changes in a child's level of care. He feels that effective transitions out of residential treatment will require cross-training, extended visitation, and family support and after care services.

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- Texas House of Representatives. 2010. Committee on Human Services. Public Hearing. 81st Legislature, Interim Session, June 30, 2010.

**Committee: How does RCCL handle violations of minimum standards at RTCs?**

Residential Treatment Centers (RTCs) are subject to:

- ? at least one unannounced monitoring inspection each year.
- ? At least once annually, an unannounced inspection is conducted by a team of at least two Licensing inspectors from different Licensing units, who work together to evaluate and assess overall compliance of the facility.

*Note: These two requirements could be accomplished with one inspection. For example, if the monitoring frequency of the facility is annually, and we haven't been out all year (which would be extremely rare given the nature of regulating RTCs), then staff would conduct the unannounced team inspection to meet the requirement to conduct a team inspection and the requirement to inspect the facility annually.*

*Another way to look at it is say the assigned inspector has conducted several inspections throughout the year, some announced and some unannounced, but the team inspection hasn't happened yet, then the inspector and another staff would still need to conduct the unannounced team inspection together to meet the team inspection requirement.*

The purpose of each monitoring and team inspection is to evaluate compliance with applicable Licensing laws, administrative rules, and minimum standard rules. Facilities are given an opportunity to correct deficiencies by a specified and agreed upon date. Compliance of serious or repeated deficiencies may be verified during a follow-up inspection; while correction of minor deficiencies may be verified via fax, phone or email. Licensing staff may conduct more frequent inspections of a facility if the

compliance history indicates deficiencies are not corrected on time, are repeated, or the type and number of deficiencies indicates an increased risk to children in care.

All minimum standards are evaluated at least once every two years. At each inspection Licensing staff review the facility's list of employees and evaluate for compliance with background check requirements. In addition, licensing staff evaluate all areas of the facility that are accessible to children, for obvious health and safety concerns and compliance with applicable standards. Staff may also choose to interview children and staff, and may review a sample of personnel and children's records, or other facility records such as serious incident reports to determine compliance with minimum standards.

At the conclusion of the inspection, licensing staff;

- ? conduct an exit interview with the person in charge, which includes reviewing any deficiencies being issued as a result of the inspection;
- ? provide technical assistance as needed to facilitate compliance with minimum standards; and
- ? provide a copy the final inspection report.

Minimum standards for RTCs are available on our website at: [http://www.dfps.state.tx.us/documents/Child\\_Care/Child\\_Care\\_Standards\\_and\\_Regulations/2010\\_09-01\\_GRO-RTC\\_748.doc](http://www.dfps.state.tx.us/documents/Child_Care/Child_Care_Standards_and_Regulations/2010_09-01_GRO-RTC_748.doc)

**Committee: Have there been any recent changes - since June 2010 - in how RCCL handles violations of state minimum standards at RTCs?**

Since May 2010, Licensing continues to assess its regulation of RTCs for compliance with minimum standards as well as its investigation practices of abuse and neglect of children in the care of a residential facility. Licensing has researched regulation models from other states and has completed 21 comprehensive reviews of residential treatment centers to assess and analyze risk to children. Licensing has also completed an enforcement team conference, consisting of an inspection by a Licensing inspector, investigator and at least one supervisor, on every RTC and has analyzed the trends and

information generated from them. Several opportunities were identified to strengthen RCCL and improve the quality of care of children in RTCs and the following changes have been made:

- ? Because the Houston area has a disproportionately high number of RTCs, DFPS has added 11 RCCL staff to the Houston area to support inspections and investigations in residential facilities.
- ? A more comprehensive unannounced inspection protocol has been developed and implemented requiring on site follow up to abuse/neglect investigation and serious deficiencies. The protocol also requires that at each on site follow up staff must interview at least three staff and three children in care and evaluate child-to-caregiver ratios and background checks for compliance with minimum standards.
- ? For abuse and neglect investigations in RTCs, Licensing has strengthened its interviewing techniques to more fully address the possible relationship issues and concerns involving children and caregivers subject to the investigation.
- ? Licensing is working with CPS and the Child Advocacy Centers (CACs) across the state to make sure RCCL is included in memorandums of understanding that will provide Licensing investigators more access to the CACs.
- ? DFPS' Center for Program Coordination is conducting an analysis of CPS/APS/ and RCCL investigation training, policies, and practices to identify needs and gaps and developing training to address them.

There are additional changes to policy and/or practice currently being evaluated for effectiveness and feasibility, including increasing the frequency of inspections, more thoroughly addressing how the operation has addressed deficiencies related to discipline, supervisor or restraint, and strengthening the technical assistance given to providers with standards violations.

**Committee: What are the types sanctions for violations of minimum standards at RTCs? How often have they been applied at RTCs since 2005?**

A data request has been submitted and should complete by November 5.

**Committee: Additional contextual information?**

## RCCL Prior to DFPS Reform

Residential Child Care Licensing (RCCL) regulates foster care, adoption, and care of children in facility settings such as residential treatment centers and emergency shelters. RCCL conducts inspections in these settings based on minimum standards set in the Texas Administrative Code. RCCL also conducts abuse/neglect investigations in these settings, with results of these investigations documented in the Texas central registry of child abuse/neglect. RCCL has just over 200 staff and regulates approximately 250 facilities and over 200 child-placing agencies which represent almost 9,000 foster homes.

Prior to 2005, RCCL was struggling to keep pace with the growth and changes in the residential child care industry. Residential treatment facilities were accepting children with more intense emotional and behavioral challenges, and rules related to psychotropic medication and emergency behavior intervention were not keeping pace with these changes in the industry.

## DFPS Reform I

The 79<sup>th</sup> legislative session, in 2005, marked Reform I for DFPS. For RCCL, Senate Bill 6 resulted in several significant changes to the regulation of residential child care. Changes specific to residential treatment centers included:

- ? Increased the minimum qualifications for Licensed Child Care Administrators (at residential facilities) and required Licensed Child-Placing Agency Administrators (at foster care and adoption agencies)
- ? Required residential operations to self-report more serious incidents, including an illness that requires hospitalization of a child, child arrest, child runaway, and child-on-child abuse.
- ? Increased background check requirements for residential operations, including submitting the background check request before a person has access to children.
- ? Required drug testing for residential child care employees, including pre-employment, ongoing, and based on allegations of drug use.
- ? Required residential operations to provide emergency behavior training approved by RCCL.
- ? Required an exit conference for each inspection of a residential operation, including providing the operation a copy of the inspection checklist.

## **2007 Minimum Standards Revisions**

Beginning in 2004, RCCL began work on a complete overhaul of the RCCL minimum standards rules. Licensing hosted both internal and external workgroups, researched safety issues and expert opinions, and conducted a fiscal analysis of proposed new rules. Three public hearings were conducted, which coincided with an extended public comment process. New minimum standards became effective January 1, 2007. Examples of more significant changes to residential treatment centers, at that time, included:

- ? Increased child/caregiver ratios
- ? Increased staff training requirements
- ? Increased serious incident reporting requirements (based on Senate Bill 6)
- ? Increased requirements for Treatment Directors
- ? Increased list of child rights
- ? Increased requirements for discharge planning
- ? Increased requirements related to medications

## **DFPS Reform II**

The 80<sup>th</sup> legislative session, in 2007, marked Reform II for DFPS. With regard to RCCL and residential facilities, Senate Bill 758 added a new requirement that at least once annually, an unannounced inspection be conducted by a team of at least two Licensing inspectors from different Licensing units, who work together to evaluate and assess overall compliance of the facility.

## **Continuing Challenges for RCCL**

### **Investigations**

RCCL currently faces multiple challenges related to investigations. First, with Senate Bill 6 requiring residential child care providers to self-report significantly more serious incidents, investigations for RCCL have risen accordingly. Although all incidents required to be self-reported directly relate to the health and safety of children in care, many of these investigations result in no finding of abuse or neglect and no finding of a

standards violation related to the incident. Therefore, RCCL is challenged to continue responding to these reports and ensuring the health and safety of children, while also attempting to make the best use of RCCL staff time in conducting inspections and investigations.

The most challenging of the self-reports are injuries related to physical restraints. While the injuries are typically minor, RCCL consistently struggles with facilities and caregivers who use restraint as discipline and/or as a method to control children's behavior, rather than as a true crisis management tool. RCCL staff frequently investigate restraint-related injuries that resulted from a restraint that simply was not necessary. While RCCL has specific minimum standards related to de-escalation, minimal force, and not using restraint as a discipline method, enforcing these largely clinical concepts can be a challenge. This is particularly true for Licensing staff who have no prior work experience with emotionally disturbed children.

Using restraints as an example of the challenge between regulation and ensuring capacity at residential treatment centers so children can be treated, there are inherent challenges when Licensing wants the use of restraints to be reduced, medical providers want the use of psychotropic medications reduced but at the same time regulatory requirements increase and the facility is held responsible for restraint-related injuries or conversely, for behavior that doesn't change or improve as a result of the facility's intervention. With Licensing having a lower tolerance approach related to restraints (in an effort to better ensure restraints are used only as a true crisis management tool), there is an related impact to providers who've indicated that the reimbursement rates do not promote the hiring and retaining of higher quality staff and caregivers with more therapeutic skills, knowledge and education that would likely reduce the use of restraints.

Balancing regulatory expectations and enforcement actions with Child Protective Services' need for placements remains challenging. Child Protective Services (CPS) is the largest consumer or services regulated by RCCL, and residential child care providers consistently express concern that they cannot provide adequate care based on the HHSC reimbursement rates. Although many fund-raise to fill the gap, this is becoming more difficult in the current economy. The struggle to adequately fund their programs can result in residential child care providers only able to do the minimum; unable to offer the higher quality or innovations that CPS and all parents would hope and expect for their children in care.

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December 28, 2010

The Honorable Patrick Rose  
House Committee on Human Services  
P.O. Box 2910  
Austin, TX 78768

Dear Chairman Rose,

We would like to extend our appreciation to you and your staff for all the hard work and leadership you have demonstrated over the past two years as Chairman. The responsibilities of this committee are challenging, and meeting the needs of the elderly and those with physical disabilities is a difficult task.

We applaud the efforts of you and your staff in preparing the committee recommendations laid out in the House Committee on Human Services Interim Report. While we agree and substantially support all the items in the report, we must take exception to the committee's position on interim charge #3 which deals with the feasibility of instituting a comprehensive, single point of entry system to simplify and expedite the process of accessing long-term care services for the elderly and individuals with physical disabilities. Though we understand the need for long-term care, there is concern with presumptive eligibility and the fiscal impact on the state for those people who could be deemed ineligible. As Texas resolves a budget shortfall in the upcoming session, we must oppose the creation of new programs that require adding FTE's to oversee the state program and any potential unfunded mandates on local government entities.

Therefore, we cannot endorse the report in its entirety.

Sincerely,

A handwritten signature in blue ink that reads "Drew Darby".

Drew Darby

A handwritten signature in blue ink that reads "Gary Elkins".

Gary Elkins