ORGANIZATIONAL ASSESSMENT

OF THE

DEPARTMENT OF STATE HEALTH SERVICES

DECEMBER 1, 2006

ORGANIZATIONAL ASSESSMENT

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EXECUTIVE SUMMARY

The purpose of the assessment was to identify opportunities to improve the performance of the Department of State Health Services (DSHS), particularly by examining the agency's high-level organizational structure and the method by which important decisions are made. As the assessment was being conducted, the scope was extended to such areas as the agency business support functions, behavioral health services and the DSHS Agency Council.

Conducting this assessment at this time recognizes that with DSHS now two years old and with a transition of commissioners, this is a good point to consider opportunities to refine the agency's structure and operations. While there are opportunities to improve the agency's effectiveness and functioning, DSHS leadership and staff have accomplished much in bringing the agency through its first two years of existence.

DSHS is a large and complex agency. Given the scope of this assessment and the limited timeframe available, this assessment is heavily based on interviews with DSHS staff and several key stakeholders within state government. Appendix I lists the 25 persons interviewed in conducting this assessment. It should be noted that DSHS staff were all highly cooperative and open in discussing even sensitive topics.

The body of this report is organized topically with the initial topics addressing organizational issues and decision-making at the agency. Later topics address business functions, behavioral health and the DSHS Agency Council. Those discussions provide background information and support for the findings and observations below and the recommendations at the end of the report.

FINDINGS AND OBSERVATIONS

Relating to the DSHS Commissioner Position,

1. The position of DSHS Commissioner should ideally be filled by a person who is an effective and astute administrator, a respected medical professional, an effective spokesperson on health issues and a strong external representative for the agency.
2. The Commissioner position at DSHS is subject to especially significant external expectations and time demands because the Commissioner is the state's leading spokesperson on public and behavioral health matters. External activities must be balanced against the need to direct and manage a large organization.
3. The previous Commissioner excelled at the external dimensions of the position and was instrumental in repairing external relations problems that had afflicted the Texas Department of Health (TDH). The Commissioner also oversaw marked improvements in TDH financial operations, a key factor in rebuilding confidence in that agency, as TDH became the operational foundation for DSHS.

Relating to Decision-making and Internal Operations,

4. Responding to external needs has limited the ability of the Commissioner to address some matters of internal operations in such areas as: follow through on priorities and assignments; assessment and resolution of crosscutting issues; synthesis of information; and coordination of actions across the agency.
5. The DSHS executive staff has operated in a consensus decision-making model to such an extent that issues would be unaddressed if a consensus was not evident.
6. DSHS has utilized a two-tier system of executive staff meetings that is ineffective in reaching decisions, complicates communication flows and provides inadequate guidance and direction to the assistant commissioners who run the agency programs.

Relating to the Deputies and Assistant Commissioners and the Centers,

7. The responsibilities of the single deputies at the other health and human services agencies under HHSC purview are fragmented among three persons at DSHS, and communications and information sharing do not take place to overcome that fragmentation.
8. The relationship between assistant commissioners and deputy commissioners at DSHS has many elements of a line management relationship, something that is inconsistent with the underlying vision for the HHS agencies.
9. The assistant commissioners receive helpful guidance and support from their deputies.
10. The three Centers, which report to the single deputy at the other HHS agencies, report to three persons at DSHS, creating barriers to communications and information sharing.
11. The multiple deputy structure, combined with the quasi-line management role of the deputies and the diffused location of the three centers, results in an agency that is divided into silos rather than unified at the deputy level.
12. Improvements in executive correspondence and document preparation are occurring but additional resources should be devoted to that function and other external relations functions.
13. The Office for the Elimination of Health Disparities, now in the Center for Program Coordination, could be enhanced if relocated to HHSC to function at an Enterprise level.

Relating to Business Support Functions,

14. There is pervasive discontent among DSHS program staff with the support provided to them by the business functions of the agency although there is confidence in the leaders of the business functions and a recognition of the challenges the business functions have faced.
15. Staffing levels and staff recruitment and retention problems are impacting the performance of the business support functions.
16. The location of contract and procurement functions is an unresolved issue in the agency.

Relating to Behavioral Health,

17. Behavioral health officials within DSHS feel that, while there has been progress, it remains a continuing challenge to elevate their issues and have their needs understood in an agency dominated by legacy TDH staff and business processes. This is especially true with respect to the state mental health facilities.
18. At this time, DSHS should still be cognizant of the need for understanding of behavioral health matters when making executive staffing decisions.
19. Much activity has occurred and is planned in terms of developing linkages between services for public health, mental health and substance abuse; however, this activity appears to be occurring without a defined vision of what the agency ultimately wishes to achieve in integrating or linking these services.

Relating to the DSHS Agency Council,

20. The DSHS Agency Council does not work well in general and does not like its role in reviewing rules. Difficulty in adapting from a governing role to a policy-focused role, a lack of clear direction and leadership, and a lack of attention by senior executives to the interests of the council have contributed to a less coherent approach to council responsibilities.

Relating to the DSHS Culture,

21. There is a risk that a new Commissioner may be captured by the legacy TDH culture since that culture has not yet been fully replaced by a new DSHS culture.

Relating to the Division of Regional and Local Health Services

22. Careful consideration needs to be given to the evolving relationships DSHS public health regions have with DSHS program offices and HHSC regional administrative service centers and to the role of the Division of Regional and Local Health Services.

ORGANIZATIONAL ASSESSMENT

DEPARTMENT OF STATE HEALTH SERVICES

AGENCY OVERVIEW

The Department of State Health Services (DSHS) was created by House Bill 2292, 78th Texas Legislature, Regular Session, 2003. The bill transferred to DSHS all functions of the Texas Commission on Alcohol and Drug Abuse (TCADA), Texas Department of Health (TDH), and the Texas Health Care Information Council, and the mental health services of the Texas Department of Mental Health and Mental Retardation (TDMHMR). DSHS began operations on September 1, 2004.

The mission of DSHS is to promote optimal health for individuals and communities while providing effective health, mental health, and substance abuse services to Texans. The Department accomplishes its mission by operating programs and delivering services that fall into four broad categories: behavioral health, consisting of mental health and substance abuse services; preparedness and prevention services; community health services; and regulatory services. Within each of these broad areas an array of services is provided. In the aggregate DSHS provides a very broad and diverse array of services and functions. DSHS provides its services at 9 office locations, 127 sub-offices, 11 mental hospitals and 2 public health hospitals. Local partnering agencies are integral to many of the services DSHS provides. Some of the services DSHS provides address special needs populations while other services benefit the general public.

DSHS has a total of 11,717 employees with 7,288 of the employees working at the state hospitals for persons with mental illness, 284 employees at the two public health hospitals, 993 employees at regional and local offices for public health services and 3,152 employees at headquarters in Austin. The FY 2007 operating budget for DSHS totals $2.5 billion.

DSHS ORGANIZATIONAL STRUCTURE

In its general contours the organizational structure of DSHS follows the organizational framework of the other three health and human services agencies under the purview of the Health and Human Services Commission (HHSC) but there are noteworthy exceptions. The following discussion reviews the high level organizational structure of DSHS with a particular focus on the respects in which the formal structure differs from the model in use at the other three agencies and in which the actual functioning of the agency differs from the functioning implied in the organization chart.

The Commissioner-Assistant Commissioner Relationship As with the other three HHS agencies under HHSC purview, a single Commissioner heads the agency. As envisioned when the HHS agencies were reorganized under HB 2292 each Commissioner should have hands on involvement in the operations of the agency. The newly constituted agencies were structured in part to foster the operational awareness and involvement of Commissioners. Each of the HHS agencies, including DSHS, places the executive level responsibility for the delivery of program/client services with its assistant commissioners. DSHS started with four assistant commissioners and now has five assistant commissioners. To assure that HHS commissioners were close to agency operations and the delivery of services, no other positions were placed on the organizational charts between the assistant

commissioners and the commissioners of the agencies. The assistant commissioner positions at the four agencies, including DSHS, were drawn as direct line reports to the commissioners. The two deputy positions at DSHS, as with the single deputy positions at the other three agencies, are also direct reports to the Commissioner.

A frequent comment by those interviewed for this assessment is that the Commissioner position at DSHS has had a very heavy external focus and, as a result, a more limited focus on internal operations. The heavy external focus and the previous Commissioner's strength in external relations are widely seen as having been crucial to rebuilding external relationships and credibility after TDH encountered serious problems several years earlier. However, the strong external orientation does appear to be at variance with the assumption underlying the organizational structures of the HHS agencies, and it appears to have contributed to the need to make adaptations in the actual functioning of the agency relative to the framework established on the organization chart.

The Assistant Commissioner-Deputy Commissioner Relationship The relationships between the assistant commissioners and the Commissioner and between the assistant commissioners and the two deputies reflect adaptations from the relationships depicted in the organizational chart. The deputy commissioners, in practice, clearly play an intermediary role between the Commissioner and the assistant commissioners. While the deputies emphasized their role in assisting, supporting and consulting with the assistant commissioners, several persons interviewed for this assessment stated that in most respects the assistant commissioners report to and are supervised by the deputy commissioners. At the very least the deputies were delegated some aspects of line management over the assistant commissioners, and they have a level of operational involvement that was originally envisioned for the Commissioner's role. Direct contact between the assistant commissioners and Commissioner does occur, but is much less frequent than direct contacts between the assistant commissioners and the deputies.

As noted, DSHS operates with two deputies. One deputy (BH) has behavioral health expertise and oversees the assistant commissioners for mental health and substance abuse services, and community health services. The other deputy (PH) has a public health expertise and oversees the assistant commissioners for prevention and preparedness, regulatory services, and regional and local health services. The organization chart indicates that the two deputies share responsibility for the line supervision of the Center for Policy and Innovation, the Center for Program Coordination, and the Center for Consumer and External Affairs. In practice, however, BH oversees the Center for Policy and Innovation, PH oversees the Center for Program Coordination and the Chief Operating Officer (COO) oversees the Center for Consumer and External Affairs.

The deputies are perceived by the assistant commissioners who work with them as providing helpful expertise and consultation based on their areas of expertise. The assistant commissioners also see the deputies as essential sources of support and advocacy in relating the needs of an assistant commissioner to the Commissioner or the executive team. Conversely, as befitting a line reporting relationship, most of the assistant commissioners would find it awkward to advance an issue or position to the Commissioner or the Executive Leadership Team (ELT) without the approval of their deputy.

The Deputy Role From a broad organizational perspective, the principal benefit of having two deputies, rather than one, is that it divides the broad array of DSHS programs and services between two people, thereby allowing each person to have more in-depth involvement in their areas of responsibility. This may have been the rationale for establishing two deputy positions at DSHS. However, having two deputies has also had ramifications for the agency.

One consequence of having two deputies is that it creates a silo effect at the deputy level that would not be present in a single deputy model. Since the deputies have at least informal operational oversight responsibilities, the silo effect extends to operational issues as well as to the functions of the Centers for which the deputies were always intended to have line management responsibility. Overcoming this silo effect would require proactive coordination and information sharing between the deputies. There is a broadly held perception within DSHS that the two deputies seldom coordinate or share information with each other.

With respect to the three Centers, the silo effect is further aggravated because the Center for Consumer and External Affairs reports to the Chief Operating Officer. In the organizational model of the HHS agencies the COO could be viewed as being a third deputy because the Centers are central to the responsibilities of the deputies in the HHS model. It appears that directors of the centers and their staffs do take steps to coordinate with other centers as needed but this requires more effort than it would if the Centers weren't reporting to three different executives.

The COO Position With respect to the COO position, the placement of a Center under the COO is clearly an anomaly in the structure of the HHS agencies. That decision by the previous Commissioner was evidently the result of the COO's expression of interest in that center's responsibilities and the COO's legislative background. The other adaptation of the COO position is the occasional use of the COO to sponsor or direct key projects that do not fall under the COO's organizational lines of responsibility. In giving the COO a broadened portfolio of assignments it appears that the previous Commissioner was responding to expressions of interest by the COO and the recognition that some assignments do not have an obvious organizational home.

DECISION-MAKING PATTERNS

The ability of DSHS to make timely and thoroughly assessed decisions at the executive level was cited as a problem by key external officials and by some of the DSHS staff members interviewed for this assessment.

Every Thursday the Department Leadership Team (DLT) meeting is held. This meeting includes the Commissioner, the assistant commissioners, the deputies, the center directors, and the general counsel. These meetings typically involve a briefing by the Commissioner on the Executive Commissioner's staff meeting, updates from the COO and the CFO and a round robin of updates from the others present. These meetings are not seen as conducive to vetting of issues or making decisions.

Executive Leadership Team (ELT) Meetings The DSHS Commissioner holds an Executive Leadership Team (ELT) meeting on Mondays. This meeting involves a smaller inner circle consisting of the CFO, the COO and the two deputies. Others, such as assistant commissioners and center

directors, sometimes attend for specific issues. These meetings are for reaching decisions or assessing strategic issues.

Comments from several persons suggested that in its actual functioning ELT meetings were not effective as a forum for making fully considered and timely decisions. There was a strong desire for the ELT to reach consensus on decisions. When a consensus did not emerge, issues would often be tabled with no action taken and no defined path or timeline to achieve resolution. One commenter noted that it became preferable to avoid bringing issues to the ELT.

Resolution of Issues The difficulties experienced by the ELT in resolving non-consensus issues illustrates a larger problem that was spoken to by many persons interviewed. There is a gap in the leadership structure of someone with the time, ability, willingness and authority to gather the appropriate staff and really work though contentious issues to either make a decision or facilitate an understanding of the options for an ultimate decision-maker. Factors that have contributed to this situation include the external demands that limit the time availability of the Commissioner, the fragmentation of the deputy role and the absence of any other position empowered to make decisions broadly affecting the agency.

Decision-making on issues bridging across program and business functions is also problematic. Program staff report they are hesitant to raise issues the CFO and COO might not agree with because they see those as very powerful positions, and they don't perceive that there is anyone who can and will broker a decision that requires balancing business support needs against the operational needs of programs. In their view the business side will always get the last word if there is disagreement. Deputies may provide valuable support and advocacy for the needs of programs, but they are not positioned or empowered to resolve such issues.

OVERSIGHT AND COORDINATION OF INTERNAL OPERATIONS

Several external and internal interview comments point to another functional gap within the leadership structure of DSHS. Specifically this involves the need for someone to provide follow through on key projects and assignments and to integrate and synthesize information from across the agency. Again these perceived needs result from the combination of the external time demands on the Commissioner and the fragmentation of the deputy role among three persons. Two comments in relation to this need were "if the Commissioner is the agency's external person who is the agency's internal person" and "whose job is it to make sure the trains run on time." The need is for someone to have the time, ability, willingness and authority to do those things. On this point it should be noted that among the ELT members there was disagreement on this need but commenters outside the ELT and outside DSHS generally agreed that there was a gap in terms of synthesis of information and follow though on key assignments and projects.

The Governor's Director of Homeland Security expressed especially strong concerns about DSHS oversight and follow though on plans, initiatives and assignments his office needed DSHS to complete. Frustrations or concerns about the pace and direction of DSHS efforts evidently were expressed to the previous Commissioner on more than one occasion but the experience of the Homeland Security Office was that after a brief period of time, progress would stop because of a lack of follow through.

THE ROLE AND PLACEMENT OF THE CENTERS

As noted, the three centers at DSHS are under the direction of three different executives. This contrasts sharply to the three centers all being under the single deputies at the other three HHS agencies under HHSC's purview. The organizational placement of the centers illustrates the fragmentation of the HHS deputy role at DSHS. The center directors all indicated that they recognize the importance of working with the other centers and stated that they make efforts to coordinate and communicate with the other centers. However, it is clear that this requires more effort than it would if the centers reported to the same person. The other consequence of placing the centers under three persons is that it creates a barrier to enabling someone at the deputy level to develop a holistic understanding of the issues, coordination needs and innovation opportunities facing the agency. It also complicates efforts to ensure effective communication to external stakeholders on priority matters. The worst-case scenario would be if the executives overseeing the centers employed the resources of their centers to advance narrow agendas that might not reflect agency priorities.

The Office for the Elimination of Health Disparities In relation to the Centers, it should be noted that the Center for Program Coordination, consisting of 28 total positions, houses two small offices that are unique to DSHS. These are the five-person Office of Border Health and the four-person Office for the Elimination of Health Disparities. The appropriate location within the HHS Enterprise of the Office for the Elimination of Health Disparities has been a subject of discussion for some time. The Office has a statutory mandate to focus on human services disparities as well as health disparities. The Health Disparities Task Force, appointed by the Governor and supported by the Office for the Elimination of Health Disparities, has long recommended that the Office be placed at HHSC. The rationale behind the recommendation is that placing it at HHSC would give the office more visibility and weight, and would enhance its ability to focus on the broader consideration of human services disparities consistent with its statutory mandate. Movement toward transferring the office to HHSC is now underway. Given the broad potential scope of its focus and the need for it to establish information sharing and working relationships across the enterprise, it is appropriate to locate this office at HHSC just as other enterprise-oriented functions are located at HHSC.

Document and Correspondence Preparation An important area of responsibility that now rests with the Center for Consumer and External Affairs and that has been a source of problems is the coordination, tracking and quality assurance of official correspondence and documents, including memoranda and briefing documents provided to HHSC. From the time DSHS was created until May 2006, document and correspondence coordination, tracking and quality assurance were primarily the responsibility of one staff person in the Commissioner's Office. During this time, quality and timeliness were persistent problems in relation to documents and correspondence prepared for or provided to HHSC.

The assessment identified several factors as contributing to these problems. There are indications that responsiveness to HHSC requirements for document preparation and timeliness was not consistently viewed as a high priority by DSHS staff. The DSHS culture was characterized by relatively informal internal communications (often relying on oral communications) and by the use of multiple formats for conveying written information to the DSHS Commissioner. This culture did not mesh with HHSC's need for standardized communication formats to succinctly and consistently organize information flowing to HHSC from across the HHS Enterprise.

Additionally, the person responsible for correspondence and other formal documents was not well supported within DSHS. It's unclear who, if anyone, provided a high level review of these documents for tone and substance. Often this individual had to make decisions on content more appropriate for senior management. The system for routing, review and approval of memoranda and correspondence was also deficient in that, assignments and the documents prepared in response to assignments often bypassed the chain of command, thereby weakening accountability and quality assurance.

Since May 2006, the responsibility for executive communications and correspondence tracking has been placed with a staff person in the Consumer Affairs Branch of the Center for Consumer and External Affairs. Indications are that systematic refinements are underway that are beginning to improve performance in these functions. Incoming items requiring a response are now being routed to single points of contact appointed by assistant commissioners rather than directly to subject matter experts, and the approval process now requires approval by assistant commissioners before the response is sent to Stakeholder Relations. Timelines for responding to legislative correspondence have also been tightened.

While the ongoing efforts to improve these functions are encouraging, two concerns remain. First, the person now coordinating this function is not proximate to the Commissioner or the deputies organizationally or physically, and this function is one that requires direct access to the Commissioner at times. Second, cultural changes will need to take root for the correspondence and document preparation responsibilities to experience sustained improvements. The new Commissioner will need to repeatedly emphasize strong performance on these functions because employees cannot always appreciate the importance of excellent customer service on these functions, and they face competing demands on their time. The Commissioner will also have to hold people accountable for performance in this area.

Another area of concern involves the resources available to the Consumer Affairs Branch. In addition to executive communications and correspondence, this branch is responsible for DSHS Council support, stakeholder communications and coordination, DSHS advisory committee appointments, working the HHS Ombudsman on complaints and inquiries, assessment of consumer satisfaction, volunteer services support and coordination, and acceptance of donations. With six FTEs, the branch is understaffed to handle this array of responsibilities. Given the importance of the external relationships handled by this branch the addition of a modest amount of resources to this branch could greatly benefit the agency.

BUSINESS SUPPORT FUNCTIONS

A widely expressed sentiment expressed within DSHS is frustration with the business support functions under the CFO and the COO. These frustrations are so prevalent that they constitute a significant employee morale issue. Among the specific frustrations expressed were: excessive and overly centralized approvals of routine managerial actions; slowness in paying bills, even at times impairing service delivery; lack of data for managing budgets; lack of managerial input into or understanding of operating budget development; a lack of written procedures explaining how to accomplish administrative tasks; slowness in procurement and contracting; and inadequate IT support for program specific needs. Program staff also expressed a perception that resources for some

administrative functions were taken from them while some of the work either remained with their offices or was later returned to their offices.

There are several common threads in the critical comments regarding the business support functions. First, the COO and the CFO are seen as being very powerful because no person balances program operational needs against the needs or desires of the business support offices. Second, there is an apparently broad feeling among program staff that it seems as though the programs exist to support the business functions rather than the other way around. Third, program staff view the business functions as being more oriented to controlling them than to assisting them.

At the same time, the CFO and the COO are seen as having strong competencies and wanting to improve the support they provide to programs. However, there is frustration that progress occurs slowly, if at all, in spite of the intentions of these senior executives. This is viewed in part as resulting from staffing issues such as high turnover in the CFO's area and difficulty in attracting appropriately skilled information technology staff under the COO. There is also recognition that agency consolidation and other changes across the HHS system placed great challenges on the business support functions that probably resulted in some customer service issues needing to take a lower priority for a while. There is also a recognition that several years ago the decentralized financial operations were in a state of disarray and that the current CFO and previous Commissioner responded effectively to those inherited situations partly by imposing firm centralized financial controls.

The assessment found that the CFO and COO have engaged in efforts to understand the concerns of program staff and they are aware of the specific concerns expressed by program staff. Those officials also cite staffing reductions occurring in their functions in 2004 as contributing to these difficulties, and it was also explained that program staff still sometimes misunderstand which support functions are performed by DSHS and which are centrally performed by HHSC.

Activities are underway which, if sustained, should address some of the issues with these services. Nevertheless, the extent and degree of the concerns expressed warrants the new Commissioner making it a high priority for the agency to make its business support processes more responsive and user friendly to program staff.

Location of the Client Services Contracting Unit An organizational question pertaining to the business support functions involves the location of the Client Services Contracting Unit (CSCU). In two other HHS agencies, this type of unit is under the COO along with the Contract Oversight Units. At DSHS the CSCU is under the CFO, while the contract oversight function is under the COO.

The CFO and the COO both support placement of the CSCU in their offices. The COO cites the following advantages of placing the CSCU under the COO: consistency with the HHS enterprise approach of focusing contracting accountability under the COOs; communication flows regarding contracting coming from a single office; closer ties between the contract oversight function and the procurement functions performed by the CSCU; and the ability to resolve issues more quickly.

The CFO also cites a number of reasons the CSCU should remain under the CFO. A major reason cited is the need for CSCU staff to work closely with budget staff to ensure that procurements are in compliance with allowable uses of funds and federal grant requirements. These compliance questions

are viewed as being especially important for DSHS because of the requirements associated with DSHS' numerous state and federal funding sources and grants. In general, the easier coordination between CSCU and budget and accounting staff is offered as a key benefit of leaving this function under the CFO. Another consideration offered is that the current arrangement allows the contract oversight function to be more objective in its assessment of contracting activities.

The perspectives offered by the CFO and the COO both have validity and that may explain why the question about the organizational location of the CSCU persists. The agency should be able to make either arrangement work. Beyond the factors offered for consideration by the COO and the CFO, several other questions should be considered. First, at this time a key priority for the CSCU should be developing clear written procedures and instructions to make it easier for agency staff to navigate the procurement process. Is the ability to achieve that objective affected by the organizational placement of the unit? Would a reassignment of the unit divert time and energy away from improving the procurement function? Would the CSCU and the procurement function benefit from the fact that the COO position at DSHS appears to have fewer and less complex competing priorities than the CFO position at DSHS?

A final consideration is whether the agency has made sufficient progress in resolving contract issues for which TDH was cited in audits over the past few years. If not, providing new leadership over the procurement function may be beneficial. DSHS Internal Audit should be requested to evaluate the agency's current exposure to past audit issues regarding contracting.

If consideration of these factors, as well as the points raised by the CFO and the COO, yields no compelling reason to reassign the CSCU, the unit should remain under the CFO rather than endure the disruption and instability of being reassigned.

BEHAVIORAL HEALTH

In creating DSHS, two types of behavioral health services, mental health and substance abuse, were added to the public health responsibilities of TDH. While DSHS is a new agency legally and in many operational aspects, TDH was clearly the foundation of the new agency even though 62 percent of the employees and 37 percent of the operating budget relate to behavioral health. Most senior executives, including the Commissioner, have a TDH and public health background and most key business personnel and processes were inherited from TDH.

During the assessment, the assimilation of the behavioral health services into a legacy TDH environment was considered and several themes emerged. First, while acknowledging that some progress has been made, persons connected with behavioral health conveyed that it has taken sustained efforts to educate key personnel on the unique needs of the behavioral health services and especially the state mental health hospitals. They characterized TDH processes as being bureaucratic, highly centralized and slow and especially poorly suited to administering acute care mental health facilities in a dynamic environment. The previous Commissioner's understanding of the needs and issues facing the state hospitals was viewed as being enhanced by opportunities to visit the hospitals and by having to wrestle with crisis or near crisis issues.

Hospital representatives state that, while progress is occurring, they still experience business processes (which may relate to enterprise processes as well as DSHS processes) that are too slow or overly centralized. Examples cited are delays in being able to arrange for contract physicians, a state hospital patient being denied admission to a local hospital because of nonpayment for previous services to a state hospital patient, employee grievances that previously were handled at individual hospitals now requiring assistant or deputy commissioner involvement and a "demoralizing" lack of authority for hospital superintendents to manage their FTEs or budgets.

An additional perspective of behavioral health officials concerns the understanding of their issues at the highest levels. They note with the current structure and staffing only two of the top ten agency executives have a behavioral health background and on the ELT it was only one of five persons. Recognizing that DSHS Commissioners are most likely to have a public health background it is seen as very important for a deputy to have a behavioral health background. Otherwise, the Assistant Commissioner for Mental Health and Substance Abuse Services would be the only person at the executive level with an understanding of this large and complex part of DSHS services. One commenter observed that eventually the agency should develop to a point where there is a general understanding of behavioral health among many agency executives but the agency has not reached that point yet.

Two other areas of inquiry relating to behavioral health are the degree of progress in linking mental health and substance abuse services and progress in linking physical health and behavioral health services. The establishment of such linkages was one of the rationales for placing substance abuse, mental health and health services in the same agency.

The review briefly explored efforts by DSHS to link these services as envisioned in enacting HB 2292. The information provided on this point indicates that numerous initiatives are underway, many of them funded by project grants. The activity clearly reflects dedicated efforts to linking and integrating these services. A piece that is missing from this effort, however, is a plan setting forth a vision for the integration and linkage of these services, and reflecting specific goals and priorities. Without a defined vision of where the state needs to go, it is difficult to assess if the efforts to date represent marginal or substantial progress in fulfilling the intent of HB 2292. Additionally, it is difficult to know if the various projects represent responses to opportunities or available funding or prioritized efforts toward specific goals and objectives.

THE DSHS AGENCY COUNCIL

The DSHS Agency Council was universally and unequivocally viewed by those commenting on it as not functioning well. In particular, council members who were formerly members of agency governing boards are seen as not adapting well to the policy role of the new agency council. DSHS has an unusually heavy volume of rules because of its regulatory responsibilities. The Council is perceived as not welcoming its role in reviewing and making recommendations on rules. The Council's resistance to reviewing rules is viewed as resulting from the Council not having the final approval on rules and because the breadth and diversity of DSHS programs ensures that most rules the Council will consider do not relate to the narrower areas of interest and expertise that attracted some of the Council members to the Council. Another factor cited in explaining the "dysfunctional" performance of Council is that without responsibility for the overall operations and performance of the

agency, the Council members lack a shared responsibility to force them to coalesce or compromise on issues.

Several persons also suggested that the agency could improve the satisfaction of the Council members if a senior executive was assigned responsibility for serving as a point of contact for the Council and facilitating opportunities for Council members to have early opportunities to have involvement and information on matters of special interest to them.

Council relations and support have been delegated to the Consumer Affairs Branch in the Center for Consumer and External Relations. While Consumer Affairs makes commendable efforts to support the Council, it simply cannot take the place of a senior executive as a point of contact for the Council. A governing board would usually have direct regular access to an agency head regarding issues and agency business while receiving logistical support from a lower level staff person. While the Council does not have the responsibilities of a governing board, a connection point to a senior executive would be beneficial and appropriate.

In general, the activities of the council seem not to have been guided by a coherent vision and commitment to the role and purpose of the Council. The Council's attention has been directed toward more narrowly focused issues rather than opportunities to engage the broad policy issues within the agency's jurisdiction.

RECOMMENDATIONS

To address concerns relating to the DSHS organizational structure, oversight and coordination of internal operations, and agency decision-making patterns, the following recommendations are offered:

1. Collapse the two deputy positions at DSHS into a single deputy position. Refocus the deputy position on policies, rules and other forward looking and integrative activities and initiatives. The single deputy should be able to develop and act on a big picture understanding of where the agency is, where it is going, and where it needs to go to accomplish its mission. The deputy should be a key resource for the Commissioner in helping to formulate and implement policy direction for the agency. Because of the Deputy's focus on policy issues, the Deputy, in support of the Commssioner, should serve as the executive point of contact for agency council members with responsibility to strengthen Council relations.

2. Place the Center for Program Coordination, the Center for Policy and Innovation, and the Center for Consumer and External Affairs under the Deputy Commissioner and allow the Deputy Commissioner to reallocate resources and restructure these units to best meet the needs of the agency. Placing these centers under the Deputy Commissioner will support the Deputy's ability to have a holistic understanding of the issues and opportunities facing the agency.

3. Create a position in the Commissioner's Office that can have broad involvement in the day-to-day operations of the agency, addressing both program functions and business support functions. This position should address weaknesses in the current executive operations of DSHS by performing the following functions:

   a. Making timely and thoroughly considered decisions within a realm of responsibilities delegated by the Commissioner.
   b. Working with staff to frame issues and options on matters the Commissioner will need to personally address.
   c. Providing follow-through on key issues and key projects.
   d. Proactively initiating action to address agency performance issues.
   e. Serving as a catalyst to organize and initiate action on projects cutting across agency divisions.
   f. Monitoring and in some instances participating in or giving direction to agency communications or interaction with stakeholders.
   g. Achieving balanced resolution of significant issues involving conflict between program and business support offices.

   This position should be filled with a person who complements the Commissioner's relative weaknesses. Presumably, successful large scale administrative experience should be a paramount consideration while a background in DSHS services and legislative processes would be strong preferences.

The position described can best function if it is viewed by agency staff as speaking for the Commissioner. A key to the effectiveness of the position will be how much it is empowered and supported by the Commissioner, especially in dealing with other executive staff.

It is suggested that the title, specific placement and duties of this position be worked out between the Executive Commissioner and the new DSHS Commissioner based on an assessment of the new Commissioner's particular strengths and the ongoing external requirements of the Commissioner position.

4. If a position as described above is added to the Commissioner's Office, the Center for External and Consumer Affairs should report to the Commissioner's Office. If no such position is created the Center should report to the Deputy Commissioner because it will need someone other than the Commissioner to be available for guidance on many matters.

To address concerns relating to the Center for Program Coordination,

5. The Office for the Elimination of Health Disparities should be transferred to HHSC to enable it to more effectively address human services as well as health services across the HHS Enterprise, consistent with its statutory mandate.

To address concerns relating to the Center for Consumer and External Affairs,

6. The new commissioner should consistently emphasize the importance of strong performance on document and correspondence response to DSHS staff, including executive staff, to support ongoing efforts to improve those functions. The Commissioner should also hold staff responsible for poor performance in this area and directly engage the staff carrying out these functions to provide guidance, expectations, ideas and support. The Commissioner's direct emphasis on these functions will be necessary to bring about changes in the organizational culture, since employees do not always recognize the importance of excellent performance in these functions and have competing priorities for their time.

7. DSHS should provide additional resources to the Center for Consumer and External Affairs where a small infusion of resources would strengthen performance in such areas as correspondence and document preparation, stakeholder relations and Council support.

To address concerns relating to agency business support functions,

8. The Commissioner should articulate it as a high priority for the agency to make business support processes more efficient and responsive to the needs of program staff.

9. The Commissioner should charge executive staff with developing a business process improvement plan that would involve the following:

a. Establishing a timetable to achieve needed improvements on a prioritized basis.
b. Assessment of the resource needs of the business support functions.
c. Assessment of the staff recruitment and retention issues in the business support functions.
d. Evaluation of whether procedural controls and required approvals are appropriately balanced against the need for managers to efficiently and effectively execute responsibilities.

To address concerns about the Client Services Contract Unit (CSCU),

10. The CSCU should not be organizationally reassigned unless the reassignment would clearly improve contracting accountability or the ease with which program staff can navigate agency procurement processes. The review was inconclusive regarding whether reassigning the function from the CFO to the COO would bring about such improvements.

11. DSHS Internal Audit should review past audit issues regarding DSHS contracts and assess the agency's continuing exposure to such issues. If continuing exposure is found to exist, the location and role of the CSCU should be re-evaluated.

12. A top priority of the CSCU should be the development of clear guidance and instructions to help program staff efficiently navigate agency and enterprise procurement processes.

To address the integration of behavioral health and public health,

13. DSHS should develop a written plan that communicates specific goals, objectives and priorities for the integration of mental health services and substance abuse services. An objective of bringing mental health and substance abuse services into the same agency and the same division was to establish linkages between these services, recognizing that many persons often require both types of services. While commendable activities in this direction have taken place, such activities should occur in the context of defined goals and objectives. Stakeholder input should be obtained in establishing the goals, objectives and priorities of such a plan.

14. DSHS should develop a written plan that communicates specific goals and objectives for the integration of behavioral health services and public health services. A primary objective of bringing behavioral health and public health into the same agency was to establish linkages between these services. While many specific activities have occurred, it is best that such activities occur in the context of established goals, objectives and priorities. Without this context, it is difficult to determine whether the state has taken big steps or small steps toward the integration of behavioral health and physical health services. Stakeholder input should be obtained in establishing the goals, objectives and priorities of such a plan.

15. Active pursuit of the integration of behavioral health services and physical health services should be viewed as a priority for DSHS executives with public health responsibilities, as

well as those with behavioral health responsibilities. While some public health personnel did express a desire to incorporate behavioral health considerations, the review found that this type of integration is primarily viewed as the responsibility of the BH deputy and the Assistant Commissioner for Mental Health and Substance Abuse Services.

To address concerns related to the DSHS Agency Council,

16. A senior executive staff person should be assigned the responsibility of strengthening relations with the DSHS Agency Council by proactively communicating with Council members on subjects of interest and serving as a central point of contact for Council members regarding agency business.

APPENDIX I

Interviewee List

Albert Hawkins, Executive Commissioner, Texas Health and Human Services Commission (HHSC)
Dr. Charles Bell, Deputy Executive Commissioner for Health Services, HHSC
Tom Valentine, Senior Policy Analyst, HHSC
Cindy Mendl, Executive Clerk, HHSC
Nora Saldivar, Special Assistant to Deputy Executive Commissioner for Health Services, HHSC
Steve McCraw, Director of Homeland Security, Office of the Governor
Heidi McConnell, Special Assistant, Budget, Planning and Policy, Office of the Governor
Machelle Pharr, Chief Financial Officer, Texas Department of State Health Services (DSHS)
Randy Fritz, Chief Operating Officer, DSHS
Cathy Campbell, General Counsel, DSHS
Jane Nussbaum, Director of the Center for Consumer and External Affairs, DSHS
Kirk Cole, Director of Government Relations, DSHS
Tommy Boukhris, Correspondence Coordinator, DSHS
Rosamaria Murillo, Director of Consumer Affairs Branch, DSHS
Dr. Dave Wanser, Deputy Commissioner, DSHS
Joe Vesowate, Assistant Commissioner, DSHS
Evelyn Delgado, Assistant Commissioner, DSHS
Dr. Rick Danko, Director of the Center for Policy and Innovation, DSHS
Kenny Dudley, Director of State Mental Health Facilities, DSHS
Dr. Nick Curry, Deputy Commissioner, DSHS
Dr. Janet Lawson, Assistant Commissioner, DSHS
Debra Stabeno, Assistant Commissioner, DSHS
Kathy Perkins, Assistant Commissioner, DSHS
Mary Soto, Director of the Center for Program Coordination, DSHS
Tom Martinec, Director, Internal Audit, DSHS

APPENDIX II

DSHS ORGANIZATIONAL CHART
OCTOBER 2006

Department of State Health Services Organizational Chart October 2006