Chapter VI

Department of Aging and Disability Services External/Internal Assessment

The Department of Aging and Disability Services (DADS) was created by House Bill 2292, 78th Legislature, Regular Session, 2003, to administer human services programs for the aging, for persons with disabilities, and for persons with mental retardation. The Department is scheduled to begin formal operations on September 1, 2004.

The material in this chapter is arranged as follows:

- Challenges and Opportunities;
- Current Activities by Goal:
  - Service Descriptions;
  - Target Populations; and
  - Other Trends and Initiatives;
- Internal Assessment; and
- Strategic Priorities.

For consistency, the same outline is used in each of the agency chapters.

Challenges and Opportunities

Maintain the Continuum of Services for Older Texans

The aging of the population is an HHS system challenge as discussed in Chapter III, and it has important implications for DADS service delivery to older Texans. House Bill 2292 requires DADS to serve as the Texas State Unit on Aging (SUA) under the Older Americans Act (OAA) of 1965 and to implement the requirements of Texas Human Resource Code Section 101.022. Older Americans Act programs are designed to help people 60 ages and over maintain their health, personal independence, dignity, and ability to contribute to society. The major functions of the State Unit on Aging are:

- Administering and ensuring accountability for funding of services and opportunities through a network of 28 area agencies on aging;

- Improving state and local capacity for "Aging Texas Well" by serving as a comprehensive resource, developing tools and resources, establishing public-private partnerships, and conducting policy research; and
- Advocating for residents of long-term care facilities and older Texans in general.

To meet the challenges presented by the OAA, the Department has placed the State Unit on Aging Oversight function under the direction of the Center for Program Coordination. This will serve as the visible focal point required by the OAA and will ensure compliance with its other provisions.

The Department must comply with requirements in the OAA to ensure that federal funds under the OAA are not jeopardized. Within the context of a new, large agency, DADS will establish appropriate management processes to continue the holistic approach by the legacy agency to aging issues and provision of a full-continuum of services authorized by the Act.

Contracting and Oversight of Local MR System

Several changes occurring simultaneously pose challenges to the contracting and oversight of local community centers' service delivery. Currently operating with a unified contract and multidisciplinary team oversight, community mental health (MH) and mental retardation (MR) or (MH/MR) centers and the services they offer will be challenged by the split of mental health and mental retardation programs into two separate departments. For fiscal year (FY) 2005, performance contracts with local authorities will be developed jointly by DSHS, DADS, and the local MHMR authority. Additionally, as a result of S.B. 1182, 78th Legislature, Regular Session, 2003, the performance contract between local authorities and the respective department is being piloted in two local authorities in FY 2005. In the pilots, performance contracts will be individually negotiated, based on the needs and priorities identified in the local service area plan developed by each of the local authorities. The two departments will need to work closely together to ensure a holistic approach in oversight of the community MHMR centers. Pilot results may determine an approach to facilitate oversight functions.

A complicating factor is the shift in funding methodology for general revenue (GR) funded services, from a quarterly allocation of funds (grant-in-aid) to a reimbursement methodology (fee-for-service) and the establishment of the necessary infrastructure to support the new system. Disruptions in provider cash flow must be avoided, as they could impact consumer services and overall financial viability.

Continued development of the cost accounting methodology and the encounter-based reporting of service delivery will allow the Department to assess the amount, scope, duration, and cost of GR-funded services. These processes and the shift to

fee-for-service reimbursement will help maximize the use of state dollars by enabling the Department to identify consumers who might be appropriate for refinancing to waiver services. The fee-for-service model also allows DADS to align GR-funded services more closely with waiver program services, leading to a unified claims-processing system, a single set of utilization management guidelines, and a quality management oversight system that crosses funding streams.

Privatizing Community ICF/MR and Waiver Services

Among the provisions of H.B. 2292 is the requirement that the local MH and MR authorities may provide services only as a provider of last resort. Additionally, the bill requires privatization of all ICF/MR and waiver services programs operated by a local authority. This transfer of services to private providers may not occur before September 1, 2006. However, the development of the plan to transition services to private providers and the process of assembling a network of service providers to meet this mandate will need to begin well in advance of that date to ensure minimal disruption of services to the consumer.

The local service area plans, developed by the local MR authorities, identify the service needs and gaps of their consumer population. As new providers are identified to meet the privatization requirements of H.B. 2292, they will be required to demonstrate their ability to meet all the needs of the consumer population. The option to use the local authority as the provider of last resort is a mechanism to address gaps in services during the transition.

Increased Demand for Community- and Home-Based Services

Over the past two decades, public policy has increasingly emphasized long-term services in the community rather than institutional settings. For the past five years, this trend has been accelerated by policy direction established by the *Olmstead* decision.

As the Department reviews its services and funding mechanisms, there may be opportunities to restructure community programs and develop alternate methods to deliver services with greater efficiency. Efforts to ensure that services make maximum use of Medicaid funding will continue, with added efforts to ensure that services are tailored to specific consumer needs and circumstances. As new tools for assessment and service delivery are implemented, the Department will provide services more effectively. The Department will use various funding resources, depending on availability and individual circumstances. These efforts toward effectiveness and efficiency will serve more people and serve them better, but they may not keep pace with the demand in the coming years.

Integration of Quality Assurance and Improvement

The development of long-term care services and supports in the community has evolved to meet the changing needs and preferences of consumers. For example, the community ICF/MR programs, multiple Medicaid waiver programs, and various state-funded programs each have their own sets of oversight and monitoring requirements. Ensuring that standards of care are met, conditions of participation are achieved, and program and consumer outcomes occur as desired will present a major challenge to DADS.

Transferring the various Medicaid waiver programs operated by legacy agencies to DADS will provide the opportunity to design a single quality assurance/quality improvement system, incorporating person-directed planning, consumer choice, and control where appropriate, and outcome-based evaluation mechanisms across all program services. Alignment of GR services with waiver services allows this quality initiative to be expanded across funding streams as well. The receipt of federal quality assurance/quality improvement grant monies will significantly aid this quality system development.

Implementing the quality assurance/quality improvement grant for the HCS waiver will provide valuable lessons on how DADS may enhance quality assurance and quality improvement efforts in other programs.

Current Activities: Services, Target Populations, Trends, and Initiatives by Goal

DADS Goal 1: Long-Term Care

To enable older Texans to live dignified, independent, and productive lives in a safe living environment through an accessible, locally-based, comprehensive and coordinated continuum of services and opportunities, to provide appropriate care based on individual needs ranging from in-home and community-based services for elderly people and people with disabilities who request assistance in maintaining their independence and increasing their quality of life, to institutional care for those who require that level of support, seeking to ensure health and safety and to maintain maximum independence for the client while providing the support required.

Qualifying older persons and people with disabilities throughout Texas have access to long-term care services through a network of 41 local community mental retardation authorities (MRAs), 28 Area Agencies on Aging (AAAs), and 10 regional administrative divisions supporting local offices. These entities provide a full continuum of services, to meet the diverse needs of people with disabilities and people over age 60. The following is a brief description of those services.

Aging Services

Service Description

The 28 AAAs provide three major types of services: access and assistance, nutrition, and supportive services, including services for informal caregivers. These services are generally short term, to meet immediate needs until long-term services are available. The AAA services may also be used to provide support while the client or family circumstances stabilize and other resources are identified to meet the long-term client/caregiver service needs.

- **Access and Assistance Services**—usually provided directly by the AAA, include information, referral and assistance, care coordination, legal assistance/benefits counseling, caregiver support coordination, and long-term care ombudsman services. These services identify appropriate client needs through an intake and assessment process, and they assist the client in developing a plan of care and arranging services, which may be paid for by the AAA, other service entitlements, or private pay. Benefits counselors help consumers understand and obtain benefit entitlements. Follow-up activities, an integral part of this service, ensure the clients' needs are met in the best way and with the highest quality possible. The long-term ombudsman services use staff and more than 800 certified volunteers to serve as advocates for residents of long-term care facilities—nursing facilities and, increasingly, assisted living facilities.
- **Nutrition Services**—identified in the OAA as health promotion services provided through congregate and home-delivered meals. Congregate meals are provided in a congregate setting, which include nutrition sites, multipurpose senior centers, adult day care facilities, and multigenerational meal sites. Home-delivered meals are provided to those seniors who are assessed as homebound, frail. Nutrition services are provided through subcontractors or vendors, who must comply with the one-third recommended daily allowance and with the Dietary Guidelines for Americans, published by the Secretary of Agriculture. The OAA requires nutrition education and other elder nutrition services, such as follow-up for those clients identified as having a high nutritional risk.
- **Supportive Services**—to help older people to lead independent, meaningful, and dignified lives in their own homes and communities as long as possible. Supportive services include services such as transportation, health maintenance, health screening, income support, and training. In-home support services include homemaker, personal assistance, visiting, telephone reassurance, chore maintenance, respite care, minor residential repair, and other services as may be identified by the State Unit on Aging (SUA) in the State Plan required by federal law. These services are provided through subcontractors, or they may be authorized by the AAAs through coordination of care and/or caregiver support.

The National Family Caregiver Support Program, authorized by the OAA Amendments of 2000, provides critical support that families need in maintaining their caregiver roles. Under this program, informal caregivers are defined as either individuals caring for persons ages 60 and over, or grandparents ages 60 and over caring for a grandchild younger than 18 years. The AAAs provide support in information, assistance, counseling, and support groups, respite, and supplemental supportive services described above. Supplemental services are provided on a limited basis, to complement the care provided by caregivers. Services provided under this category include fixed route transportation, demand/response transportation, assisted transportation, emergency response, escort, home-delivered meals, homemaker, personal assistance, shopping, telephone reassurance, chore maintenance, health maintenance, income support, and residential repair.

Target Population

The sole eligibility requirement for services under the OAA is to be 60 years of age or over, or be a family member or caregiver seeking support on behalf of someone age 60 or over. However, OAA services target older individuals with the greatest social and economic need. Targeting and outreach activities include specific objectives for providing services to low-income minority individuals and older individuals residing in rural areas.

As shown in Table 6.1, Texas will experience an increase in each of these target populations. The percentage of older individuals with low incomes is expected to increase by nearly 38 percent between the years 2000 and 2010. The percent of older individuals living in rural areas between 2000 and 2010 is expected to increase by 31 percent. The greatest percentage increase is anticipated among the older minority population; between 2000 and 2010, this portion of the aging population is expected to grow by nearly 55 percent.

Table 6.1
Projected Growth in Target Populations for Aging Services

Target Population	2000	2010	% change
60+ Low-Income[1]	334,622	460,267	+37.5%
60+ Rural[2]	474,091	620,995	+31.0%
60+ Minority	782,836	1,210,411	+54.6%

[1] Low-income is defined as 100% of the Federal Poverty Level. Low-income projections assume the poverty rate remains constant.

[2] Rural projections assume the rate of seniors living in a rural area remains constant. Counties identified as rural have 51 percent or more of their population living in a rural area.

Table 6.1: U.S. Census Bureau, Census 2000, Public Use Microdata Sample (PUMS), Texas State Data Center, Population Growth Scenario 0.5, 2004.

Long-Term Care Services

Service Description

Long-term care services for persons who are older or have a disability include both community-based and institutional programs. Community-based services may be provided with or without waivers and are available to people with disabilities who meet functional, medical, and financial need criteria.

These services may be provided through Medicaid funds, Social Services Block Grant funds, or GR appropriations:

- **Primary Home Care and Community Attendant Services**—Non-technical personal care services provided to persons of all ages who are functionally limited in performing activities of daily living (personal care, home management, escort), with medical need established by a practitioner.
- **Family Care**—services provided to aged people and adults with disabilities who are functionally limited in performing daily living activities. Services include assistance with personal care activities, housekeeping tasks, meal preparation, and escort services.
- **Day Activity and Health Services**—nursing, physical rehabilitative, nutrition, and supportive services prescribed by a physician and provided in adult day-care facilities that are state licensed.
- **Home Delivered Meals**—hot, nutritious meals served in a client's home by community-based provider agencies.
- **Emergency Response**—a 24-hour, electronic, medical emergency call system for functionally impaired older people or adults with disabilities who live alone or are physically isolated from the community.
- **Residential Care**—services to adults who require access to services on a 24-hour basis, but who do not need daily nursing intervention. Care is provided in facilities licensed by DADS.
- **Adult Foster Care**—24-hour living arrangements, including meal preparation, housekeeping, and help with personal care.
- **Consumer Managed Personal Assistant Services**—services targeting adults with disabilities who are mentally and emotionally capable of self-directing their attendant care. Clients interview, hire, train, and supervise their own attendants.
- **In-Home and Family Support Services**—grant benefits to persons who are older or have disabilities, to support their living independently in the community and to prevent institutionalization. The consumer may use the benefits to purchase special equipment, medical supplies, and adaptive aids and also to modify the home and automobile to make them accessible and usable.
- **Hospice Program**—medical, social, and support services to terminally ill patients in the community or in an institution.

As an alternative to institutionalization, states may apply for waivers to allow Medicaid consumers to receive services in a community or home setting. The following are waiver services provided in the community:

- **Community Based Alternatives (CBA)**—home- and community-based services to people who are older and to adults with disabilities, as a cost-effective alternative to nursing facilities. Consumers must meet medical necessity requirements for nursing facility services. As the largest waiver program, CBA served about 30,300 Texans each month in FY 2003.
- **Community Living Assistance and Support Services (CLASS)**—home- and community-based services, as a cost-effective alternative to placement in an ICF/MR. In FY 2003, this program provided services to more than 1,860 consumers per month.
- **Deaf-Blind with Multiple Disabilities (DBMD)**—serving people who are both deaf and blind and have at least one other disability, to help them communicate and live as independently as possible. In FY 2003, this program served about 130 consumers per month.
- **Medically Dependent Children Program (MDCP)**—support services to families with medically complex or fragile children to help the children remain at home and out of long-term care facilities. The program provides respite care, minor home modification, adaptive aids, and adjunct services. In FY 2003, this program provided services to about 985 consumers per month.
- **Consolidated Waiver Program (CWP)**—a program in Bexar County, providing home- and community-based services to people eligible for care in a nursing facility or ICF/MR. This cost-effective alternative to institutional placement served approximately 200 clients in FY 2003.

In addition, the Program for All-Inclusive Care of the Elderly (PACE) is a comprehensive array of community-based and institutional services for frail older people (living in a specific catchment area) who would qualify for nursing facility placement.

Long-term care services also offer institutional nursing care to Medicaid recipients whose medical conditions require the skills of a licensed nurse on a regular basis:

- **Nursing Facility Program**—total medical, nursing, and psychosocial needs of each consumer, including room and board, social services, over-the-counter drugs (prescription drugs being covered through the Medicaid Vendor Drug program), medical supplies and equipment, and personal needs items. Nursing facilities served approximately 65,200 consumers per month in FY 2003.
- **Rehabilitative Services**—physical, occupational, and speech therapy for eligible nursing facility consumers who do not have Medicare coverage for these therapies. Rehabilitative services for persons outside nursing facilities are provided by other agencies.

- **Medicaid Swing Bed Program**—allows participating rural hospitals to use their beds interchangeably to provide acute hospital and long-term nursing facility care to Medicaid recipients, when no Medicaid beds are available in skilled nursing facilities in the same geographic area.
- **Emergency Dental Services**—reimbursement funding for emergency dental services to Medicaid consumers in nursing facilities.
- **Specialized Services**—physical, occupational, and speech therapy for Medicaid consumers determined in the Pre-admission Screening and Annual Resident Review (PASARR) process to need these services.

Target Population

Long-term care services are provided to people of all ages who meet financial eligibility requirements and have medical and/or functional needs for care on an on-going basis.

Nursing facility services are available to people who need the medical care of a licensed nurse on a regular basis. Waiver services are generally targeted to people who have a medical need for nursing facility services, who are at risk of institutionalization in a nursing facility, and who prefer to receive services in the community. Non-waiver community care services are available to people whose disabilities limit their ability to care for themselves and who may be at risk of needing nursing facility services.

Some services have age limits; for example, CBA serves adults only, and MDCP serves children only. Most services are available to all age groups. Since disabilities and serious medical conditions become more common with age, long-term care recipients are predominantly older people, with many being very old (persons ages 80 and over). Younger people, especially those under 65, are more likely to receive waiver or other community-based services. Older persons, especially those past age 85, are more likely to receive nursing facility services.

Some services are targeted to specific disabilities or medical conditions, such as the deaf-blind waiver, but most serve persons with a wide range of disabilities and conditions.

Long-term care services are available to people with limited income and resources. Some people are eligible for Medicaid under Supplementary Security Income (SSI) rules, while others have incomes up to three times the SSI amount, with limited assets. Asset limits for services funded by GR and Social Services Block Grant are higher than those funded by Medicaid.

Mental Retardation Services

Service Description

The Department offers community-based services for persons diagnosed with mental retardation or related conditions, who meet diagnostic and functional need criteria. These services may be provided through GR appropriations or Medicaid funds. All MR services are accessed through a local MRA. Services are described as follows:

- **Eligibility Determination**—an assessment or the endorsement of an assessment conducted to determine whether a person has mental retardation, and whether a person is a member of the MR priority population.
- **Service Coordination**—assistance in accessing medical, social, educational, and other services and supports to help consumers achieve the quality of life and community participation they want.
- **Support Services**—assistance for consumers not receiving residential services. These services include supported home living, respite services (in or out of home), employment assistance, individualized competitive employment, specialized therapies (support services provided by a licensed or certified professional such as psychology, nursing, social work, occupational therapy, physical therapy, speech, or behavioral health services), and family support services (to help preserve the family unit and prevent or limit out-of-home placement of an individual).
- **In-Home and Family Support Services**—grant benefits to persons who have mental retardation to support their living independently in the community and to prevent institutionalization. The consumer may use the benefits to purchase special equipment, medical supplies, and adaptive aids and also to modify the home and automobile to make them accessible and usable.
- **Day Training Services**—services provided away from an individual's home to help the individual develop and refine skills necessary to live and work in the community. This category includes vocational training and site-based habilitation services.
- **Residential Services**—24-hour services provided to a consumer with mental retardation who does not live independently or with their natural family. There are three types of GR-funded residential services: family living, residential living, and contracted specialized residences.

Medicaid waiver programs are community-based services to serve people in their communities, rather than in institutions. The programs are described as follows:

- **Home and Community-Based Services (HCS) Waiver Program**—comprehensive, community-based services and supports to eligible people with mental retardation, as an alternative to the ICF/MR program. Covered services include adaptive aids, case management, counseling and therapies (includes audiology, speech/language pathology, occupational therapy, physical therapy, dietary services, social work, and psychology), minor home

modifications, dental treatment, nursing, residential assistance, respite, day habilitation, and supported employment. In FY 2003, this program served about 8,000 consumers.

- **Texas Home Living (TxHmL) Waiver Program**—a recently approved waiver providing limited supports to help eligible consumers stay in their own or family homes, participating in family and community life. The program helps people avoid placement in the ICF/MR program. Services include community support, day habilitation, employment assistance, supported employment, respite, nursing, behavioral support, specialized therapies (includes physical therapy, occupational therapy, audiology, speech/language pathology, and dietary), minor home modifications, adaptive aids, and dental treatment.

The ICF/MR program provides residential and habilitative services, skills training, medical services, and adjunctive therapies with 24-hour supervision and coordination of the individual program plan. The programs are described as follows:

- **Community ICF/MR Program**—residential environments ranging from six beds to several hundred beds. Each ICF/MR, whether publicly or privately operated, holds an individual contract with the Department. The community ICFs/MR served almost 7,700 consumers during FY 2003.
- **State Mental Retardation Facilities (SMRFs)**—24-hour residential treatment and training services for persons with mental retardation. There are 13 facilities in Texas, and each is certified as an ICF/MR. The SMRFs serve individuals with severe or profound mental retardation and those individuals with mental retardation who are medically fragile or who have behavioral problems. Major services provided include: 24-hour residential care and support; comprehensive behavioral treatment services; comprehensive health care services; occupational, physical and speech therapies; personal life skills training; paid work programs; and services to maintain connections between consumers and their families and/or natural support systems. The SMRFs served approximately 5,000 consumers in FY 2003.

Target Population

The priority population for MR services consists of individuals who meet one or more of the following descriptions:

- People with mental retardation, as defined by Texas Health and Safety Code Section 591.003;
- People with pervasive developmental disorders, including autism, as defined in the current edition of the Diagnostic and Statistical Manual;
- People with related conditions who are eligible for services in Medicaid programs; or

- Nursing facility residents who are eligible for specialized services for mental retardation or a related condition pursuant to Section 1919(e)(7) of the Social Security Act.
- Children who are eligible for services from the Division of Early Childhood Intervention Services, now a part of DARS.

The determinations of mental retardation, pervasive developmental disorders, and related conditions must be made through the use of assessments and evaluations performed by qualified professionals. Admission to MR services is based on an individual's need and eligibility for a particular service, in accordance with rules and policy of the Department.

The Texas Mental Health and Mental Retardation Act requires that the Department identify priority populations and the minimum array of services necessary to address their needs. Table 6.2 reflects the growth of the MR population and of those qualifying as "most in need." Between 2005 and 2009, the number of individuals with mental retardation is expected to grow from 613,955 to 650,708. For individuals qualifying as "most in need"—the Department's priority population—the growth is projected to climb from 107,948 in 2005 to 114,410 in 2009.

Table 6.2
Projected Growth of Mental Retardation Priority Population

	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
MR Population	613,955	623,048	632,198	641,413	650,708
Priority Population	107,948	109,547	111,156	112,776	114,410

Table 6.2: U.S. Census Bureau, Census 2000, Public Use Microdata Sample (PUMS), Texas State Data Center, Population Growth Scenario 0.5, 2004.

DADS Goal 1 Trends and Initiatives

Demographic Changes in the Aging Population

Growth

The national growth of the aging population has been well documented. Baby boomers will begin to reach age 65 in the year 2011 and reach the very vulnerable age of 85 in 2031. The number of persons age 65 and over is projected by the U.S. Bureau of Census (1996) to reach 40 million in 2010 and 80 million in 2050.

Currently, 12.4 percent of the general population, or about one in eight people, is age 65 and over. By 2030, the age 65 and over population is expected to account for 20 percent of the total population. The minority population among those ages 65 and over is expected to grow significantly and account for 26.4 percent of the older population in 2030, up from about 17 percent in 2000.

In Texas, the number of people age 65 and over is projected to be about 2.2 million in 2005. By 2010, their numbers are projected to top 2.5 million, and will double to about 5.2 million by the year 2030. Growth among the minority population age 65 and over in Texas appears to outpace the national projections. In 2005, the minority population among persons age 65 and over is projected to be about 30 percent. By the year 2040, the minority population will account for 56 percent of the older population, with Hispanics comprising over half the older minority population.[1]

Growth of the Very Old

The aging of the population has created an additional category of the older old, meaning people age 85 and over. Among the aging, this is the fastest-growing segment of the population. There were about 4.6 million people age 85 and over in 2002. Their number is expected to double to 9.6 million by 2030. By 2040, their number is expected to grow to 14 million, and by 2050, if the highest projection series holds true, the 85 and over population could approach 31 million.

In Texas, the 85 and over population is expected to exceed 255,000 in 2005. By 2010, this population is projected to grow to more than 294,000. Projections for the year 2030 show the 85 and over population at almost 500,000, climbing to more than 831,000 by 2040. Since the older old often have severe, chronic health problems which demand special attention, the rapid growth of this segment has significant implications for long-term care services.[2]

Possible Improvements in Disability Status[3]

The age-adjusted disability rates among older persons appear to be declining. That is, a typical 75-year-old today is less likely to be impaired than was a typical 75-year-old of 15 years ago. In particular, older persons are less likely to be dependent in the Instrumental Activities of Daily Living, such as preparing meals, using the telephone, and managing money. Technological improvements have supported this trend: help with money management has significantly declined with the adoption of direct deposit and automatic bill pay options; help with meal preparation has decreased as availability of prepackaged meals and wider use of microwave ovens

[1] TDoA, "Texas Demographics: Older Adults in Texas" (April 2003), http://www.tdoa.state.tx.us/Publications/ResearchReports/NewDemographicProfile4-03.pdf (accessed April 29, 2004).
[2] Ibid.
[3] Brenda Spillman (2003). "Changes in Elderly Disability Rates and the Implications for Health Care Utilization and Cost," U.S. Department of Health and Human Services, Urban Institute.

have increased; and help with telephone use has dropped since amplifying devices and one-touch speed dialing have become common. However, the reduction in disability status through technological improvement does not necessarily imply better health.

Possible Shifts in the Sex Ratio

In the last few years, life expectancy for men has been increasing more rapidly than for women, narrowing the gap between the two groups. Over time, this trend may decrease the percentage of older persons who are living alone. Since very old persons living alone are among those most vulnerable, increased life expectancy for men may also mitigate the demand for services.[4]

Stress on the Informal System

Current estimates indicate that 25 percent of American families are involved in elder/parent care in some way, and nearly two-thirds of the baby boom generation will be caring for aging parents in the next ten years. National surveys indicate that relatives care for four out of five older people who have a disability. This informal system of care giving has been valued at $257 billion annually—more than double the national expenditure for nursing facility and paid home care combined.[5]

Recently, this informal system is experiencing stress as the pool of family caregivers shrinks. In 1990, there were 11 potential caregivers for each person needing care, but by 2050, this ratio is expected to fall to four to one.[6] The large, extended families of past generations are less common, and greater mobility among adult children often means that care giving responsibilities for aging parents fall to one child. These caregivers likely are parents themselves who are active in the work force; they are sometimes referred to as the "sandwich generation." Almost 52 percent of caregivers have some kind of workplace problem as a result of their care giving, and estimates for business losses range between $11 and $29 billion annually due to the employees' needs to care for loved ones age 50 and over.[7] [8]

[4] U.S. Census Bureau, "Aging in the United States: Past, Present and Future," http://www.census.gov/ipc/prod/97agewc.pdf (accessed April 27, 2004).
[5] National Family Caregivers Association, "Family Caregiving Statistics," http://www.nfcacares.org/NFC2002_stats.html (accessed April 27, 2004).
[6] Ibid.
[7] Christine A. Price. "Aging Families—Series Bulletin #2: The Sandwich Generation." http://www.hec.ohio-state.edu/famlife/aging/PDFs/Sandwich%20Generation.final.pdf (accessed April 27, 2004).
[8] National Family Caregivers Association, "Family Caregiving Statistics", http://www.nfcacares.org/NFC2002_stats.html (accessed April 27, 2004).

Demographic Changes in the Non-Older Person Population with Disabilities

Recent studies indicate that the disability rate is rising among working-age adults (ages 21-64). While reasons for the rise are unclear, some possible influences include improved trauma survival rates, more liberal program or insurance benefits, and increased rates of obesity. The fastest growing causes of disability among non-older persons are diabetes and musculoskeletal problems, conditions that are associated with obesity.[9] Weight has a dramatic effect on a person's ability to manage five basic activities of daily living: bathing, eating, dressing, walking across a room, and getting in or out of bed. Moderate obesity for men is associated with a 50 percent increased probability of having limitations on these abilities, and severe obesity is associated with a 300 percent increased probability. For women, the effects are even larger.[10] Increased prevalence of all disabilities will inevitably increase the demand for long-term care services, especially community-based and client-managed services.

Demographic Changes in the Population with Mental Retardation

Growth

About 2.7 percent of the general population has mental retardation, and the number of individuals with mental retardation increases as the general population increases. The projected growth of the population with mental retardation as identified in Table 6.2 reflects a six percent increase from 2005 to 2009. The projected growth in the priority population between 2005 and 2009 reflects this same six percent increase.

Aging[11]

With improved health care and health care technology, the life expectancy for individuals with mental retardation has increased from 19 years in the 1930s to 66 years by 1993. The average age at death for the general population in 1993 was 70 years. Experts observe that with continued improvement in their health status, individuals with mental retardation—particularly those without severe impairments—could be expected to have a lifespan equal to that of the general population. As people with mental retardation live longer, they will require services and supports for longer periods of time, directly impacting the finite capacities of state service delivery systems.

[9] D. N. Lakdawalla, J. Bhattacharya and D. P. Goldman (2004). "Are the Young Becoming More Disabled? Rates of Disability Appear to Be on the Rise Among People Ages Eighteen to Fifty-Nine, Fueled by a Growing Obesity Epidemic." Health Affairs, Vol. 23, No. 1, pp. 168-176.
[10] R. Sturm, J. Rengel and T. Andreyava (2004). "Increasing Obesity Rates and Disability Trends." Health Affairs, Vol. 23, No. 2, pp. 1-7.
[11] David Braddock. "Disability at the Dawn of the 21st Century and The State of the States." Washington, DC: American Association on Mental Retardation, 2002.

Stress on the Informal System[12]

The aging of the general population directly influences demand for developmental disabilities services, because the majority of people with developmental disabilities in the U.S. currently live with family caregivers. Analysis of FY 2000 data reveals that 61 percent (2.79 million) of the 4.56 million persons with developmental disabilities in the U.S. population were receiving residential care from family caregivers. Further analysis of the 2.79 million individuals who receive care from family caregivers revealed that 25 percent were living with family caregivers age 60 and over, and an additional 35 percent were in "households of middle-aged caregivers (41-59 years) for whom transition issues are near-term considerations." The remaining 40 percent were living with caregivers less than 41 years of age. This informal system of residential care served about six times the number of persons served by the formal, out-of-home residential care system (460,455 persons). As these caregivers age, they are less able to provide care, and formal living arrangements must be established to support their relatives with disabilities.

Impact on Services and Interest Lists

Long-Term Care Services

Since 1980, the overall number of persons receiving nursing facility services under Medicaid in Texas has changed very little, but the number of persons over 85, those most at risk of need for nursing facility care, has more than doubled. The nursing facility program is a Medicaid entitlement program, and as such can grow in response to demand without the need for waiting lists. However, the relative stability of the nursing facility population numbers reflect that far more Texans now receive care in the community than receive nursing facility care.

The demand for community-based care in Texas is not being fully met, and the population needing services continues to grow. Some community care programs such as the Primary Home Care, Community Attendant Services, and Day Activity and Health Services are Medicaid entitlement programs that can grow in response to demand. Medicaid waiver programs, however, are not entitlement programs and have limited capacities. Individuals expressing interest in these programs far exceed the programs' capacities. The interest list for the CBA waiver at the end of the second quarter of FY 2004 included 63,232 individuals, and the list for the CLASS waiver included 11,072 individuals. Interest lists also exist for other community long-term care programs funded with Social Services Block Grant or GR funds, such as home-delivered meals and Emergency Response services.

Long-term care staff contact individuals on the interest list each year to confirm their desire for services. People on the interest list are not assessed until there is an opening, and about half of those assessed do not qualify for services. Senate Bill 285, 78th Legislature, Regular Session, 2003, now calls on the Department to

[12] Ibid.

forecast openings likely to become available during the next fiscal quarter, and to contact the individuals on the waiting list at least 30 days before the opening, to begin eligibility determination.

In addition to the demand for traditional, community-based services already discussed, there is a trend away from dependence on services provided by licensed agencies, in favor of personal attendants hired, trained, and supervised by the individual needing services. A small but growing number of people with disabilities prefer to manage their own services. The growing numbers of younger people with disabilities in the long-term care population tend to reinforce the move toward community-based services and the demand for client-managed services.

Mental Retardation Services

As with long-term care services, more people need mental retardation/ developmental disabilities services and supports than the systems in most states can provide. Since the 1970s, many states have reduced their reliance on institutional facilities and have developed community residential settings, including group homes, foster care, and supported living options.[13] This national trend holds true for Texas: the demand for institutional services is decreasing while the demand for community services is increasing. Between 1980 and 2004, the number of people living in large, state-operated facilities serving people with mental retardation has dropped from 10,320 to 4,978. In a residential survey[14] completed for FY 2002, of the 20,042 persons served in Texas' public and private institutional facilities, 36 percent (7,320) were served in settings with 16 or more persons. Texas served 63.47 percent of persons receiving residential services in small residential settings (1-15 beds). The demand for home- and community-based services is not limited strictly to residential services, but includes all services and supports available to persons with mental retardation, and it has created a gap between service needs and what the current system can provide. This gap is the waiting list for MR services.

Texas is not alone in facing this issue; there are waiting lists in every state. Gary A. Smith summarized the waiting list phenomenon in the National Association of State Directors of Developmental Disability Services Special Studies Initiative Report on

[13]Rizzolo, M. C., Hemp, R., Braddock, D., & Poneranz-Essley, A. "The State of the States in Developmental Disabilities." The University of Colorado, Department of Psychiatry and Coleman Institute for Cognitive Disabilities. 2004.
[14]Prouty, R., Smith, G., & Lakin, K. C. (Eds.). "Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2002." Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration. 2003.

waiting lists.[15] He identified seven factors that account for the high rate of demand for long-term services and supports. These factors include:

- Increasing longevity of people with developmental disabilities;
- Demographic impact of the baby boom generation;
- Redirected demand (from nursing facilities to community-based care) on the developmental disabilities system;
- Broadening of eligibility criteria in some states;
- Higher family expectations concerning services and supports;
- The increased demand that occurs when people become aware that new services have been funded; and
- Changing economic demands on family.

Demographic trends clearly suggest that as baby boomers age, waiting lists will increase markedly, unless a concerted state/federal effort is mounted to address this issue.

Waiting lists initiatives in the states have generally involved expanding family support to prevent or delay the need for institutional placements.[16] States have also been obtaining new or reallocated resources from the following sources: institutions, ICF/MR conversion to Medicaid Waiver programs, refinancing of state general revenue with Medicaid funding, capping reimbursement for existing programs, and seeking additional Medicaid funding.

In Texas, at the conclusion of the second quarter of FY 2004, there were 25,560 individuals waiting for MR services. Of the total number waiting, 24,502 (96 percent) were waiting for services from the Medicaid HCS Waiver. Interim GR-funded services are provided to 53 percent of the waiver waiting list group. Staff of the local MR authorities contact individuals on the waiting list annually to confirm they still need and want waiver services.

Older Americans Act

The OAA Amendments of 2000 (Public Law 106-501) extend the Act's programs through FY 2005 and make several changes, including:

- Creation of the National Family Caregiver Support Program;
- Creation of new targeting requirements for rural elders;
- Increased budget authorization for certain service categories;
- Consolidation of funding for certain services;
- Creation of new cost-sharing provisions;

[15] Gary A. Smith. "Closing the Gap: Addressing the Needs of People with Developmental Disabilities Waiting for Supports." Alexandria, VA: NASDDDS Special Studies Initiative Report. 1999.
[16] K. Charlie Lakin. "Perspectives. On the Outside Looking In; Attending to Waiting Lists in Systems of Services for People with Developmental Disabilities." *Mental Retardation*, 1998, Vol. 36, pp. 157-162.

- Expanded authority for categorical transfers and state waivers;
- Consolidation of reporting and reimbursement process for meals under the USDA; and
- Addition of three new areas for research, training, and demonstration projects.

Permanency Planning

Permanency Planning is a philosophy and planning process that focuses on the outcome of family support for children with developmental disabilities. This is achieved by facilitating a permanent living arrangement for a child with an enduring and nurturing parental relationship. Senate Bill 368, 77th Legislature, Regular Session, 2001, made numerous changes to state law regarding permanency planning for individuals with developmental disabilities.

This bill extends the age range to 22 years for permanency planning for each individual with a developmental disability who resides in an institution or for whom institutional placement is sought. The bill also expands the definition of institution to include not only ICFs/MR, but also group homes operated by DFPS, nursing facilities, DFPS-licensed institutions for people with mental retardation, and foster homes. The legislation mandates that admission of an individual under age 22 to an institution is considered temporary and may be initially approved for only six months. It outlines a review and monitoring system involving the Commissioner or designee for approval of admission or extension. It also provides for the appointment of a volunteer advocate to assist in the permanency planning process. Lastly, it requires that the names of all individuals under age 22 admitted to an institution be placed on the appropriate waiver waiting list.

During FY 2003, the Department ensured that every child with a developmental disability in a nursing facility was identified and re-evaluated to determine whether the child could return to a home setting. Children with mental retardation were referred for MR services. Children with other developmental disabilities were referred to community care programs for services.

Helping Nursing Facility Residents Return to the Community

A group of initiatives and legislative changes are enabling people who receive nursing facility care to return to the community more easily.

Money Follows the Client

Medicaid clients in nursing facilities who wish to relocate to the community can do so more easily. The funding that had been used to provide their nursing facility services is transferred to the community program. The interest list is not affected.

Housing Voucher Program

This program, created in May 2002, helps former nursing home residents who are transitioning to the community gain access to affordable, accessible housing. The program is a collaborative effort among DADS, HHSC, the Texas Department of Housing and Community Affairs, and the U.S. Department of Housing and Urban Development.

Transition to Life in the Community Grants

These grants target people moving from nursing facilities into the community, providing one-time assistance funds for initial rent and utility deposits, other relocation-related expenses, and household items needed to re-establish residence in communities. In FY 2005, these grants will become part of the CBA waiver, rather than a separate program.

Community Awareness and Relocation Services (CARS)

This pilot program began in June 2002, serving Austin, Corpus Christi, Crockett, Houston, and Temple. The CARS contractors raise community awareness about available community alternatives, care and support options, and accessing services. The relocation activities include identifying nursing facility residents who are interested in returning to the community, assessing their transition needs, and helping them with the transition process. Services are now available on a wider geographic basis.

New Freedom Initiative

President Bush's Executive Order 13217: Community-Based Alternatives for Individuals with Disabilities, also known as the New Freedom Initiative, was issued on June 18, 2001. The order directed a government-wide review of federal policies to identify ways to allow people with disabilities to live in and participate fully in their local communities. The 1999 Supreme Court ruling in the *Olmstead* case and this Executive Order have committed the nation to helping people with disabilities to overcome barriers to community living.

In March, 2004, a progress report on the New Freedom Initiative was published. The report summarizes the actions federal agencies have taken in the following areas:

- Health care structure and financing;
- Housing;
- Personal assistance, direct care services, and community workers;
- Caregiver and family support;
- Transportation;
- Employment;
- Education;

- Access to technology;
- Accountability and legal compliance;
- Public awareness, outreach, and partnerships;
- Income supports;
- Gathering, assessment, and use of data; and
- Cross-agency collaboration and coordination.

Federal agencies involved in carrying out the Executive Order developed agency-specific plans to implement actions to enhance community integration and remove federal barriers to integrating people with disabilities into the fabric of community life. This progress report also begins identifying the "next steps" in fulfilling the vision outlined in the New Freedom Initiative.

Increased Recipient Control of Services

Persons receiving personal attendant services in the community may opt to select, train, hire, and manage their own attendants. Few have chosen to exercise this option of complete control and responsibility. With the help of federal funding, the Department is developing a hybrid service management option that allows consumers to select, train, and supervise their attendants but leaves fiscal, personnel, and backup responsibilities with a provider agency.

Senate Bill 367

Senate Bill 367, 77th Legislature, Regular Session, 2001 requires that consumers with mental retardation, their legally authorized representatives (LARs), and, if the LARs are not family members, at least one family member, each be provided information regarding all care and support options available to the consumer. The bill also codified the Living Options process to help make decisions about care-setting options.

The bill created an HHSC advisory committee, named the Interagency Task Force on Ensuring Appropriate Care Settings for Persons with Disabilities, to guide the development of the *Texas Promoting Independence Plan*, discussed above. Under H.B. 2292, the task force was preserved and renamed the Promoting Independence Advisory Committee. Most of the committee members represent a variety of stakeholder groups, including consumer and family interests. The committee is charged with advising HHSC about achieving the objectives of the Promoting Independence Initiative.

Senate Bill 367 also requires a memorandum of understanding (MOU) between the legacy DHS and the legacy Department of Mental Health and Mental Retardation for a pilot study in several locations to address the coordination of services for people with mental illness or mental retardation who want to transition to the community from nursing facilities. The program is now being expanded statewide under DADS.

DADS Goal 2: Regulatory and Licensing Services

Provide licensing, certification, and contract enrollment services, as well as financial monitoring and complaint investigation, to ensure that residential facilities, home and community support services agencies, and individuals providing services in facilities or home settings comply with state and federal standards and that clients receive high-quality services and are protected from abuse, neglect, and exploitation.

The Division of Regulatory Services handles the Department's oversight, administrative, and regulatory responsibilities for long-term care services to about 305,400 older persons, people with disabilities, and people with mental retardation. In FY 2002, about 66,800 consumers lived in nursing facilities, and about 218,000 consumers received disability services in the community. Additionally, there were over 5,400 individuals receiving services in state MR facilities, over 8,100 people in community ICF/MR programs, and more than 6,800 individuals participating in MR waiver services.

By statute, all long-term care facilities meeting the definitions of nursing homes, assisted living facilities, adult day care facilities, and privately owned ICFs/MR must be licensed and must comply with all licensure rules to operate in Texas. Publicly operated ICFs/MR (state or community MH/MR centers) and skilled hospital units must also be certified to participate in Medicare and/or Medicaid. Home and Community Support Service Agencies (HCSSAs) also fall under the Department's licensing and certification review functions. In FY 2003, the Department regulated 1,176 nursing facilities, 1,385 assisted living facilities, 2,597 HCSSAs, 907 ICFs/MR, and 404 Adult Day Care facilities.

Waiver program providers are reviewed and certified for compliance with the program certification principles. The Department conducts an annual, on-site certification review of the program provider to evaluate compliance. Based on the review, corrective actions may be required and sanctions imposed.

The Quality Management staff oversee compliance of local authorities with the MR performance contract requirements. These requirements include responsibilities for planning, policy development, coordination, resource development and allocation, and oversight of MR services in the most appropriate and available setting to meet individual needs in a local service area.

The regulatory division also provides federal certification for facilities participating in the Medicaid and Medicare programs. Provider agencies served through the program include those that provide licensed home health services, licensed and certified home health services, home dialysis, hospice services, and personal assistance services. House Bill 2292 requires the Department to explore using the Joint Commission on Accreditation of Healthcare Organizations standards and processes for regulatory functions.

The regulatory division is responsible for more than facility surveys. When a provider applies for licensure, the division reviews the applicant's history as a provider, obtaining detailed information on operators, owners, and other controlling persons. The division assesses all this information and approves or denies the application accordingly. The division also pursues enforcement actions against facilities cited for non-compliance with regulations, manages Medicaid contracts, and provides information to the public as appropriate.

The Department operates four credentialing programs that license, certify, permit, and monitor individuals to determine whether they can be employed in facilities and agencies regulated by the Department. These programs are as follows:

- **Nursing Facility Administrator Licensing and Investigations Program**—responsible for licensing and continuing education activities; imposing and monitoring sanctions; providing due process considerations; and developing educational, training and testing curricula. Investigating complaints or referrals, coordinating sanction recommendations and other licensure activities with the Governor-appointed Nursing Facility Administrators Advisory Committee. In FY 2002 there were 2,227 licensed nursing facility administrators.
- **Nurse Aide Registry and Nurse Aide Training and Competency Evaluation Program**—responsible for nurse aide certification and sanction activities; approving or renewing Nurse Aide Training and Competency Evaluation Programs (NATCEP); withdrawing NATCEP approval, and providing due process considerations and a determination of nurse aide employability in nursing facilities regulated by the Department via the Nurse Aide Registry. In FY 2002 there were 95,238 certified nurse aides.
- **Employee Misconduct Registry**—responsible for providing due process considerations and a determination on employability of unlicensed staff in facilities and agencies regulated by the Department (including HCSSAs).
- **Medication Aide Program**—responsible for medication aide permitting and continuing education activities, issuance, and renewal; imposing and monitoring of sanctions; providing due process considerations; approving and monitoring of medication aide training programs in educational institutions; developing educational, training, and testing curricula, and coordinating and administering examinations. In FY 2002, there were 6,564 permitted medication aides.

DADS Goal 2 Trends and Intiatives

Like other states, Texas faces many challenges in assuring and improving quality in its long-term care programs. Ensuring the health and welfare of program participants in institutional care is typically accomplished by a centralized oversight system, with medical, behavioral, and direct care staff readily available on-site.

Quality Outreach

Created through Senate Bill 1839, 77th Texas Legislature, Regular Session, 2001, this technical assistance program is a service for providers of long-term care. The program consists of three components that provide a non-regulatory framework for fostering improvements in the quality of resident services.

- **Quality Monitoring**—provides problem-oriented technical assistance by monitors, who are nurses, pharmacists, and dieticians, to long-term care facility staff. The program uses a systems-analysis approach to identify and address the causes of lapses in the use of evidence-based practices. Through unannounced visits, monitors perform structured resident assessments to identify system-level lapses in the application of best practices to resident assessment, care planning, and care delivery.
- **Joint Training**—provides opportunities for regulators and providers of long-term care services to participate in an educational process that addresses both clinical knowledge and knowledge of regulations to foster a common and shared understanding. The emphasis of this training is on the care issues that lead to the 10 most frequently cited deficiencies in long-term care.
- **Long-Term Care Facility/Surveyor Liaison**—provides a conduit for communication between facility staff and survey team members to resolve medical issues and improve nursing performance in long-term care facilities. These staff members jointly maintain medical/nursing knowledge regarding state and federal facility surveys. They also perform advanced clinical/nursing reviews of certification surveys, licensure inspections, and investigations conducted in long-term care facilities to determine medical compliance with state/federal requirements and protocols, to ensure clients receive optimal care.

A collaborative relationship exists with the LTC Ombudsman Program and advocacy groups to promote quality initiatives. In addition, Texas contracts with the Texas Medical Foundation to assist providers in quality improvement efforts. The last 24 months of work toward quality improvement in nursing facilities has led to rapid reduction in restraint use, marked improvement in the evaluation of residents for whom indwelling catheters are used, and modest improvement in providing needed toileting assistance. The Department has also begun to work with long-term care providers toward improvements in pain assessment, pain management, fall risk management, resident and staff immunizations, dietary care planning, preventing dehydration, and improving advance care planning.

Redesign of Quality Assurance/Quality Improvement System

Community-based service programs face a major challenge of ensuring the health and welfare of all participants living in the community while preserving their privacy and right to make choices. To enhance quality management, the Department strives for consistency across the state while balancing the needs of local community participants, families, and other stakeholders in a variety of supports and services.

To test the capability of this system, the Department is redesigning and improving the information-gathering system to integrate existing waiver quality assurance and quality improvement reporting mechanisms into a comprehensive data collection system and process. The HCBS Quality Framework—a quality initiative of the Federal Centers for Medicare and Medicaid Services (CMS)—is being used as a guide in this process. This proposed system will ensure an accountable use of public resources and a balance between personal outcomes/flexible supports and regulatory requirements to improve the quality of the MR waiver programs.

To facilitate the proposed system redesign, the Department applied for and was awarded a Real Choice Systems Change Grant for quality assurance/quality improvement (QA/QI) by CMS. The grant will allow DADS to:

- Involve stakeholders in the development and implementation of the project;
- Research and develop a methodology to measure individual consumer experiences in MR waiver programs;
- Develop an automated critical incident reporting process to capture information identified by the QA/QI Task Force as necessary to ensure health and welfare of participants; and
- Purchase expertise to develop a centralized information-gathering system to compile results obtained through newly created sources of data (for example, participant experiences and critical incidents) and existing sources of data (for example, survey/certification review results).

System reports will be accessible to waiver participants and their legally authorized representatives, program providers, and MR services staff. A centralized information-gathering system will help disclose opportunities for quality improvement across the waiver service system, resulting in a system that will:

- Focus on the outcomes of services;
- Ensure health, safety and rights protection; and
- Ensure, through performance measures, that local authorities and program providers are in compliance with contracts and applicable rules and laws.

DADS Internal Assessment

This section represents an evaluation of the key internal factors that influence DADS. Below is a discussion of the agency's internal processes and operations, and its perceived strengths and challenges.

DADS Internal Processes

As previously noted, H.B. 2292 consolidates all mental retardation services from the TDMHMR, the community care and nursing home services of the DHS, and the

aging services of the TDoA into DADS. The Department is scheduled for integrated operations September 1, 2004 (also known as DADS Day One). In order to achieve this goal, and to meet the many changes required by H.B. 2292, a DADS Program Management Office (PMO) was established to support the development of the new organization in cooperation with the executive leadership of DADS.

To facilitate the planning for a new department and to ensure DADS is operational on September 1, 2004, several DADS Day One workgroups have been initiated. These workgroups are comprised of all levels of staff from the three legacy agencies. This cross-representation of staff, coupled with the development of specific workgroup tools, allows for the development of the business plan and identification of best practices.

These workgroups are performing detailed analyses of workflow and processes in the various current programs, business operations, and locations among the three agencies. From this inventory, the workgroups will identify:

- Current successful business processes DADS can leverage;
- Redundancies in effort and/or staff; and
- Inefficient processes.

The workgroups have been divided into two overall categories: tasks and organizational workgroups:

- The tasks workgroups are responsible for issues impacting all organizational areas in DADS (for example, websites, asset transfers and relocation, and reporting). These groups are charged with developing coordinated, streamlined, and efficient processes for the agency.
- The organizational workgroups were developed to mirror the approved, high-level organizational structure for DADS. These workgroups are charged with recommending an operational design and the associated processes and procedures to ensure uninterrupted services (despite current differences in legacy agency functions) and to improve overall efficiency and effectiveness.

In addition to these workgroups' activities, each legacy agency is continuing to track and monitor requirements for H.B. 2292. Implementation goals and strategies are in place to ensure that nothing is overlooked. Furthermore, rules, policies, and procedures for the new agency are being identified or written, and then used in the process of implementation and in preparing subsequent reports on that implementation.

DADS Internal Operations

The high-level organizational structure (Commissioner, Deputy Commissioner, Assistant Commissioners, and Departmental Division levels) has been developed and approved in a manner consistent with the conceptual outline in the *H.B. 2292*

Transition Plan. The unit and subunit structures below the Division level will be developed by the organizational workgroups through their processes. The local and regional structures for departmental presence and service delivery will also be determined through these workgroups.

The departmental PMO and DADS executive team are active participants in developing and implementing communication plans to ensure internal/external stakeholder involvement and in identifying and mitigating risks and issues during the planning and integration phases of the transition process.

Within the transition process, opportunities exist to consolidate aging, mental retardation, and disability programs and services to create a true continuum of services within a single agency. Additional opportunities will arise to combine similar programs operating concurrently in the legacy agencies, and to simplify and streamline access to and administration of programs, thus leading to greater efficiencies and improvements in service delivery.

DADS Internal Strengths and Challenges

However, within this changing environment, it is sometimes challenging to coordinate and disseminate timely and accurate information to the public about decisions on regional structure, where and how services are available, and how to access services and/or program administration. Funding streams and the associated requirements that have been developed and nurtured by the legacy agencies must also be carefully tracked to ensure their successful migration to DADS.

Given the magnitude of change in creating a new department from three existing agencies, confusion and uncertainty are bound to surface. Issues surrounding the relocation of staff, unknown administration structures, staff morale, and job insecurity are being addressed by a change management strategy that includes the following elements.

Cultural Change

Internal change consultants working with the DADS workgroups will create change management plans to systematically and effectively manage the changes related to consolidating programs, services, and employees. The goal of each change plan is to ensure DADS staff members can perform well enough so DADS may fully realize its outcomes and goals.

Change management initiatives, including orientation, training, and communication strategies, are planned and will be implemented throughout the transformation process to help employees make a smooth transition to the new DADS organization and new culture.

Communications

A communications roadmap has been developed to ensure consistent and timely communications with all internal/external stakeholders throughout the transformation. For internal communications, an e-newsletter, *DADS direct*, is issued on a regular basis. *DADS direct* includes transformation and consolidation news from the Commissioner, an update relating to transformation activities, and an overview of DADS programs and services. *DADS talk* is a newsletter for external communication that addresses these same issues.

Meetings with employees from each of the legacy agencies are scheduled throughout the transformation. These informal, open forums offer employees the opportunity to get to know DADS executive team members, receive the latest transformation information, and ask questions about transformation and consolidation activities.

Knowledge Transfer

Retirement incentives, combined with the uncertainty that accompanies change, have resulted in the loss of a number of knowledgeable and experienced staff. This will continue to be an increasing challenge in the coming months, and it threatens the maintenance of on-going operations and services of the legacy agencies as well as the transformation to DADS.

A mechanism has been built into the DADS Day One workgroup process to identify and mitigate the impact created from knowledge gaps.

Executive leadership plans on-going, collaborative efforts to balance the preparation for the upcoming legislative session with the competing priorities of maintaining current operations, preparing for DADS Day One, and identifying opportunities for optimization. In the midst of this tremendous change, the key to success is maintaining best practices and quality services while minimizing the impact to consumers.

DADS Strategic Priorities

- The following priorities express the emphasis that DADS will employ to meet agency goals and fulfill the agency mission:
- DADS will implement comprehensive, outcome-based quality assurance and quality improvement systems based on legacy agency quality initiatives and systems.
- DADS will protect and assure the health, safety and well-being of individuals in state regulated and state operated services.

- DADS will emphasize consumer choice and consumer control in the array of services offered, and will encourage single points of local access and the concept of “no wrong door” to these services.
- DADS will focus on best practices within the continuum of services to reduce the amount of time people wait for services.
- DADS will advance the objectives of the Older Americans Act including the Aging Texas Well program to ensure that state and local communities are preparing for the future.
- DADS will ensure provider accountability for cost-effective services through a quality-focused contracting system.