Chapter IX

Department of State Health Services External/Internal Assessment

The Department of State Health Services (DSHS) was created by H.B. 2292, 78th Texas Legislature, Regular Session, 2003. The bill transferred the functions of the Texas Commission on Alcohol and Drug Abuse, Texas Department of Health, Texas Health Care Information Council, and the mental health (MH) services of the Texas Department of Mental Health and Mental Retardation (TDMHMR). The DSHS began 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

Health Status Disparities

Health disparities are the "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States," according to the National Institutes on Health.[1] Common characteristics of these populations include race, culture, gender, age, economic status, and geographic distribution. The demographic changes anticipated in the next decade will likely magnify health disparities, which, left unattended, may reduce the state's productivity. A healthy workforce is instrumental to the economic and social progress that Texas makes in the future.

[1] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, “Health Disparities,” www.mentalhealth.samhsa.gov/highlights/april2002/publichealth/ (accessed April 30, 2004).

Texas' greatest natural resource is its diverse human capital. Approximately 46 percent of the state's 21 million residents are Hispanic, African American, or members of another minority race or culture.[2] Immunization rates, infant mortality, coronary heart disease, cancer, obesity, diabetes, HIV infection/AIDS, mental health, and substance abuse are important health indicators that illustrate health status disparities among racial and ethnic minorities.

Immunizations

Low levels of childhood immunizations in Texas pose a challenge to DSHS. Childhood immunizations include, but are not limited to, the vaccine series of diphtheria-tetanus-pertussis vaccine (DTaP), polio vaccine (OPV/IPV), and measles, mumps, and rubella (MMR). Texas ranked 45th among states in the U.S. for immunizing children ages 19-35 months, according to the 2002 National Immunization Survey. In this survey, Texas reported an age-appropriate immunization rate for young children of 71 percent in comparison to the national rate of 79 percent. [3]

However, since the mid-1990s, the Texas immunization rate for children has increased steadily as indicated by the Texas Immunization Survey (TIS). The statewide immunization rate among children ages 3 to 24 months rose from 61.9 percent in 1994 to 70.3 percent in 2000. By race/ethnicity, childhood immunizations rates in Texas were 73.6 percent for Anglos, 72.1 percent for African Americans, and 66.7 for Hispanics during 2000. [4]

A collaborative work with public and private entities was initiated by DSHS to increase immunization rates among children to address the requirements of Rider 35 in Article II of the General Appropriations Act from the 78th Legislative Session, Regular Session, 2003. In addition to this legislative action, the Governor issued an Executive Order on July 31, 2003 to increase the immunization rates of children in Texas, and this Order expedited the implementation of Rider 35.

Infant Mortality

The infant mortality rate (IMR) is the number of deaths to infants less than one year of age per 1,000 live births. Infant mortality historically has served as an important indicator of the overall health status of pregnant women and infants. In 2000, overall infant mortality in Texas was 5.7 per 1,000 live births. From 1990-1999, the Texas infant mortality rate declined 20 percent from 8.0 per 1,000 to 6.2.[5]

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[2] TDH, "The Health Disparities Task Force Executive Summary for the 78th Texas Legislature, February 2003." http://www.tdh.state.tx.us/minority/hdtf/ HDTF_exec_sum_rpt.pdf (accessed April 13, 2004).
[3] TDH, "Texas Department of Health Functional Review." September 2003.
[4] TDH, *Texas Immunization Survey (TIS), Immunization Division, 2000-2003*, www.tdh.state.tx.us/immunize/tis.htm (accessed March 12, 2004).
[5] TDH, "The Health of Texans: Texas State Strategic Health Plan, Part 1." July 2002, p. 73.

From 1989-1999, African American infants, on average, died at a rate twice that of all other infants who were born in Texas. The African American infant mortality rate in 2000 (11.4 per 1,000 live births) remained considerably higher than the rates for Hispanics (3.5) and Anglos (4.8).[6]

Multiple DSHS initiatives address infant mortality, such as perinatal systems development, breastfeeding promotion, and surveillance activities. Title V funds, Social Security Act, are used to deliver prenatal care and population-based services across Texas. The Department has also implemented the Pregnancy Risk Assessment Monitoring System (PRAMS), a surveillance system developed by the Centers for Disease Control and Prevention. Data from PRAMS will be used to better understand the behaviors and experiences of women who have given birth in Texas.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) helps pregnant women and infants eat well during the critical times of growth. Clients learn about nutrition and health. An important part of the WIC mission is informing clients about the importance of health care and referring them to sources of care in the community. The following individuals are eligible for WIC:

- Pregnant women;
- Women who are breastfeeding a baby under one year of age;
- Women who have had a baby in the past six months; and
- Parents, step-parents, guardians, and foster parents of infants and children under five can apply for their children.

Coronary Heart Disease

Coronary heart disease results from a reduction in blood supply to the heart. Factors associated with coronary heart disease include hypertension, tobacco use, high cholesterol levels, low physical activity, poor nutrition, and second hand tobacco smoke. In 2000, coronary heart disease was the single highest killer of Texans at 31,782 deaths.[7]

In Texas, ten-year mortality trend data show that age-adjusted rates for coronary heart disease have decreased significantly from a total of 192.2 per 100,000 in 1989 to 176.0 per 100,000 in 1998. By racial/ethnic groups, African Americans (218.4) have the highest rates of mortality per 100,000 from coronary heart disease compared to Anglos (189.1) and Hispanics (147.1) using a 2000 standard population. [8]

[6] Ibid.
[7] Ibid., p. 34.
[8] Ibid.

The primary focus of the Texas Council on Cardiovascular Disease and Stroke at DSHS is to reduce the incidence of coronary heart disease. Collaborative partners of the Council include business, health care, school, and community organizations. The Council developed a list of heart disease and stroke indicators to alert communities and assist them in promoting a heart and stroke healthy environment.

Cancer

Cancer is characterized by the uncontrolled growth and spread of abnormal cells anyplace in the body. Although death from cancer is declining, cancer is still a serious problem. The 10-year mortality trend for Texas revealed that the age-adjusted rates of cancer decreased from 206.6 per 100,000 in 1989 to 200.6 per 100,000 in 1998. In Texas and the U.S., cancer is the second leading cause of death, only exceeded by heart disease. In 2000, cancer accounted for 22.2 percent of deaths in Texas.[9]

Contributors to the incidence of cancer are tobacco use, poor nutrition, physical inactivity, obesity, and other lifestyle factors. Tobacco use is a primary contributor to lung disease, heart disease, and cancers of the mouth, breast, pharynx, esophagus, pancreas, kidney, bladder, and uterine cervix.

In 1998, 73,299 Texas residents were diagnosed with cancer. Cancers of the prostrate, breast, lung and bronchus, and colon and rectum accounted for about 50 percent of all of the 1998 cancer incidences.[10]

By race and ethnicity, African Americans living in Texas had the highest rate of cancer in 1998. The age-adjusted rate per 100,000 was 431.1 for African Americans, 394.2 for Anglos, and 272.7 for Hispanics.[11]

Obesity

In the U.S., the second leading cause of preventable mortality and morbidity is the condition of being overweight or obese, to which poor nutrition and lack of physical activity contribute.[12] A body-mass index (BMI) of 25.0-29.9 defines a person as overweight while a BMI of 30.0 or greater defines a person as obese. The Texas Behavioral Risk Factor Surveillance System (BRFSS), an annual survey of Texans' behavioral health habits, calculates the BMI using self-reported height and weight.

Based on a study by the TDH and researchers from Texas' leading universities, the conditions of being overweight or obese create a substantial economic burden in Texas, amounting to $10.5 billion during 2001. Costs of overweight and obesity

[9] Ibid., p. 35.
[10] Ibid.
[11] Ibid., p. 36.
[12] Ibid., p. 21.

could be as high as $39 billion in 2040, if population growth continues at the rates observed during 1990-2000.[13]

According to the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), more than one out of every four adult Texans were considered obese in 2002 based on their body mass index (BMI), and another 37 percent were categorized as overweight. In Texas, the rate of adult obesity varies significantly by race/ethnicity with the highest rates reported for African Americans (42 percent) and Hispanics (30 percent), compared to 22 percent for Anglos. This level of disparity by race/ethnic population was greater in Texas than in the nation overall where the rate of adult obesity was statistically the same as the state's for Anglos (21 percent), but significantly lower for African American (33 percent) and Hispanics (24 percent). Both at the state and national levels, the rate of adult obesity doubled between 1990 and 2002.[14]

Responses to the 2002 BRFSS also indicated that Texas adults were more likely to report no leisure time physical activity in the past month than the national average (29 percent vs. 25 percent). Texas Hispanics performed particularly poorly on this indicator, as 4 out of 10 Texas reported no physical activity.

Among younger Texans, the 2001 Youth Risk Behavior Survey found that nearly 14 percent of Texas high school students were overweight or obese compared to 11 percent of high school students nationally. Texas Hispanics (18 percent) and African American students (17 percent) were more likely to be overweight or obese than Anglo students (11 percent).[15] [16]

The Statewide Obesity Taskforce convened by the Texas Department of Health researched and developed a plan to address a growing overweight and obese population in a manner that takes into account the demographic diversity of its people. The plan communicates the urgency of making obesity awareness and prevention a part of daily life.[17] Texas Department of Health published *The Strategic Plan for the Prevention of Obesity in Texas* in February 2003.

Using the Plan, DSHS works with local and state level partners, including the Texas Department of Agriculture, the Texas Education Agency, and the Goal A Workgroup of the Texas State Strategic Health Partnership to promote healthy eating and regular physical activity. The partners will activate state- and community-level

[13] TDH, "The Burden of Overweight and Obesity in Texas, 2000-2040." 2004.
[14] Centers for Disease Control and Prevention (CDC). "Behavioral Risk Factor Surveillance System Survey Questionnaire. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC. 2002.
[15] CDC. "Surveillance Summaries." June 28, 2002. MMWR 2002:51 (No. SS-4).
[16] TDH, "Overweight and Obesity Risk Factors in Texas Youth: An Analysis of the 2001 Texas Youth Risk Behavior Survey." In *Chronic Disease in Texas: A Report of the Bureau of Chronic Disease and Tobacco Prevention*, July 2002. 2002:2 (Publication No. 04-11373). pp. 2-3.
[17] Statewide Obesity Taskforce, "The Strategic Plan for the Prevention of Obesity in Texas", February 2003, www.tdh.state.tx.us/phn/obesity%2Dplan.pdf (accessed March 15, 2004).

organizations to identify strategies in the plan for which they can assist in taking responsibility. In addition, the steering committee of the Goal A Workgroup will facilitate the development of partnerships, monitor the implementation of the plan, and make recommendations for plan revisions.

Much of the work is devoted to creating an environment that supports healthy habits, both dietary and physical activity, among youth in Texas schools. The Nutrition and Physical Activity Workgroup (NUPAWG) is an internal collaboration among DSHS programs to promote fitness and to work toward the obesity prevention goals outlined by the Strategic Plan for the Prevention of Obesity in Texas.

Diabetes

Diabetes is a very serious, costly, and increasingly common chronic disease. It can lead to detrimental health conditions including heart disease, kidney failure, leg and foot amputations, and blindness. The diagnosis of Type 2 diabetes is now more frequent among children and adolescents than adults. [18] Obesity and physical activity are two modifiable risk factors associated with Type 2 diabetes.

In 2000, diabetes was the sixth leading cause of death in Texas at 5,195 deaths (3.5 percent of deaths). In Texas, the five-year average age-adjusted mortality data indicated that mortality rates per 100,000 for African Americans (56.1) and Hispanics (53.3) were about two times higher than for Anglos (22.4).[19]

The Texas Diabetes Council administratively attached to DSHS addressed the rising diabetes rates in its *2004-2005 Plan to Control Diabetes in Texas*.[20] The Diabetes Council is legislatively mandated to develop and implement a state plan for diabetes treatment, education, and training. The Council identified priorities in the Plan related to diabetes prevention and treatment: surveillance and evaluation, health care improvement, professional education, public health education, public health advocacy, and community outreach. In addition, the Texas State Strategic Health Partnership addressed diabetes prevention and control through its 2010 goal to improve the health of all Texans by promoting healthy nutrition and safe physical activity.[21]

HIV Infection/AIDS

The Human Immunodeficiency Virus (HIV) is spread through sexual contact by an infected person, by sharing needles via drug injection, through transfusion with infected blood or blood products, or by mother to infant transmission. At the close of 2002, 68,327 Texans had received a diagnosis of HIV infection or Acquired Immune

[18] TDH, "The Health of Texans: Texas State Strategic Health Plan, Part 1." July 2002, p. 42.
[19] Ibid.
[20] Texas Diabetes Council, "2004-2005 Plan to Control Diabetes in Texas." www.tdh.state.tx.us/diabetes/PDF/State%20Plan.pdf , pp. 8-9 (accessed June 4, 2004).
[21] TDH, "The Declaration for Health: Texas State Strategic Health Plan, Part II." 2003.

Deficiency Syndrome (AIDS). Among Texans diagnosed with AIDS, 36,309 were still living at the end of 2001.[22]

The number of new HIV, rather than AIDS, cases in Texas remained stable from 2000-2001. Reported cases of AIDS increased by 7 percent from 2000-2001 in Texas. In Texas, the rate of reported HIV cases in 2001 among African Americans (77.0 per 100,000 population) was more than five times higher than the rate for Anglos (13.1 per 100,000) or Hispanics (14.0 per 100,000) in 2001. Also in 2001, the AIDS rate among African Americans (49.2 per 100,000 population) was more than five times higher than the rate for Anglos (8.7 per 100,000) and nearly four times higher than the rate for Hispanics (12.6 per 100,000). [23]

The HIV Community Planning Group is a cooperative effort among different groups including government agencies, non-governmental groups, and the people most affected by HIV in each community.[24] Together, these groups and DSHS study the size of the epidemic and the risk factors in Texas communities. The groups evaluate available local data, discuss which people have the greatest risk for HIV infection, and determine what type of prevention programs work best for these community members.

In addition, the HIV/STD Strategic Plan guides HIV prevention and control activities at DSHS.[25] The Plan focuses on initiatives to reduce the impact of HIV and STD infections on Texans, including increasing awareness of those infected with HIV/STD, improving the quality of community HIV/STD services, and building HIV/STD prevention and control capacity in minority communities.

Mental Health

Mental illnesses are the leading cause of disability in the U.S., Canada, and Western Europe.[26] In the U.S., mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes, second only to cardiovascular conditions and slightly more than the burden associated with all forms of cancer. [27] In Texas, about 433,000 adults met the DSHS mental health priority population definition in FY 2003. That same year the potentially eligible population of children and adolescents for MH campus and community-based programs was approximately 150,000.[28]

[22] TDH, "The Health of Texans: Texas State Strategic Health Plan, Part I, July 2002." p. 49.
[23] Ibid., p. 50.
[24] TDH, "Community Planning." www.tdh.state.tx.us/hivstd/planning (accessed April 27, 2004).
[25] TDH, "HIV/STD Strategic Plan." www.tdh.state.tx.us/hivstd/planning/background.htm (accessed April 27, 2004).
[26] World Health Organization, "The World Health Report 2001," Geneva: World Health Organization.
[27] Murray, C.J. & A.D. Lopez, Eds., "The Global Burden of Disease, A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020," Cambridge, MA: Harvard School of Public Health.
[28] Texas State Data Center and Office of the State Demographer, Department of Rural Sociology, Texas A&M System, TXSDC, www.txsdc.tamu.edu, (accessed March 1, 2004).

Prevalence of mental illness varies by characteristics such as gender, ethnicity, and age. For example, nationwide, nearly twice as many women as men suffer from a depressive disorder each year. However, four times as many men as women commit suicide with Anglo males committing 60 percent of all suicides in 2000. In both Texas and the U.S., Anglos are more than twice as likely to commit suicide as compared to African Americans or Hispanics. The highest suicide rate usually occurs among persons ages 65 and over. Over 90 percent of people who kill themselves have a diagnosable mental health or substance abuse disorder.[29]

Access to MH care may also differ by demographic variables. At a time when racial and ethnic minorities comprise a substantial segment of the U.S. population and are growing rapidly, the public sector has not kept pace with the diverse need. As a result, minority and rural populations are often underserved or served inappropriately. The Office of the U.S. Surgeon General reports that racial and ethnic minorities are less likely than Anglos to receive MH services, less likely to have health insurance, and more likely to receive poorer quality of care for a mental illness. Minorities are also overrepresented among those who are homeless, incarcerated, or institutionalized and have mental disorders.[30] Disparities in care also affect residents of underserved or rural areas, a group that comprises 25 percent of the U.S. population.

Cultural competency is a priority of the DSHS organization and service delivery system. Cultural awareness training, workforce diversity initiatives, diversity plans and diversity surveys are required of all state mental health facilities (SMHFs) and contracted community mental health centers. The Department serves as a resource by developing reference materials for distribution by mail/electronically, and by conducting training programs and educational presentations on cultural competency. To reduce future health status discrepancies, the Department is engaged in ongoing initiatives to increase cultural competence, to address access issues, and to enhance the system's responsiveness in providing culturally appropriate services to individuals from ethnically diverse backgrounds.[31]

Substance Abuse

Substance abuse is an illness that is progressive, chronic, and relapsing.[32] Biological, medical, psychological, emotional, social, and environmental factors impact substance abuse and dependence behaviors. In FY 2003, an estimated 2.97

[29] TDH. "The Health of Texans: Texas State Strategic Health Plan Part I. " 2002. pp. 90-91.
[30] U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration. Disparities in Mental Health, www.mentalhealth.samhsa.gov/highlights/april2004/publichealth/, (accessed May 11, 2004).
[31] TDMHMR, Cultural Competency Initiative, www.mhmr.state.tx.us/centraloffice/multiculturalservices/culturalcompetencyinitiative (accessed May 11, 2004).
[32] TCADA. "Statewide Service Delivery Plan." February 1, 2004, pp. iii-iv. http://www.tcada.state.tx.us/policy_info/StatewideServiceDeliveryPlan2004.pdf (accessed March 16, 2004).

million Texans needed assistance for substance abuse problems. Of these persons, approximately 2.77 million were adults and 200,000 were youth.

The legacy Texas Commission on Alcohol and Drug Abuse conducted a statewide household survey of alcohol and drug use among Texas adults from July 2000 to March 2001. Among Texas adults, 65.7 percent drank alcohol, and 5.7 percent drank alcohol heavily. The percentages of heavy drinkers by race/ethnicity were 6.2 percent of Hispanics, 5.7 percent of Anglos, and 4.5 percent of African Americans. The use of any illicit drugs (e.g., marijuana, cocaine, and heroin) was 9.4 percent of Texas adults. The percentages of illicit drugs users by race/ethnicity were 10.6 percent of African Americans, 9.3 percent of Anglos, and 9.1 percent of Hispanics. [33]

To address the problem of substance abuse, the Department initiated a strategy to implement disease management and research-based practices for prevention and treatment. [34] Disease management criteria will provide guidance to providers for defining the appropriate array of services for clients. A utilization monitoring system will ensure the effective movement of clients through the treatment continuum.

Efforts will be made to link prevention and treatment services. The development of a prevention plan was based on need, best practices, effective prevention principles, and resources. Part of the plan involves mapping the counties the greatest numbers of youth at high risk of developing substance abuse or dependency. Also, the plan includes converting prevention providers to the use of research-based curricula. The best prevention outcomes result from evidence-based and culturally appropriate curricula.

System Integration

Physical health and behavioral health are closely connected as illustrated by the positive effect of good mental health on the course of other illnesses such as cancer, diabetes, and heart disease. In the past, issues involving physical health, substance use and/or MH were addressed through the three legacy agencies of the TCADA, TDH, and the TDMHMR. House Bill 2292 consolidates these legacy agencies into a single department that addresses the health, MH, and substance abuse issues facing Texans. By serving complementary functions, preventive and treatment services will cover the spectrum of health needs of the population as a whole.

Desired outcomes of this transformation to DSHS will include the following:

- a closer alignment of public health, MH, and substance abuse services;
- an increased emphasis on collaborative care;
- an enhanced focus on prevention and early detection to avert chronic, infectious, and risky behaviors;

[33] TDH, “The Health of Texans, Texas State Strategic Health Plan, Part I.” July 2002, p. 27.
[34] TCADA, “Statewide Service Delivery Plan.” February 1, 2004, pp. 7-9.

- a seamless delivery of services; and
- a collaboration of public and private multi-disciplinary partnerships to address health issues and needs in Texas.

The integration of services offered by different systems has historically required substantial efforts and special projects. The implementation of House Bill 2292 is expected to facilitate and simplify multi-system efforts.

Coordinated efforts are also needed to address inefficiencies resulting from multiple funding streams. Ideally, qualified Texas residents would be able to access the appropriate type and amount of healthcare services without confusion or delay from DSHS. However, creating an ideal system has been challenging. State and federal funding streams have requirements and restrictions that have sometimes framed the public health organization to satisfy funding entities rather than to optimize a comprehensive and evidence-based approach to service delivery. The new relationship among public health, mental health, and substance abuse services provides an opportunity to reconsider approaches and to optimize capacity.

Consolidating three legacy agencies into DSHS brings different local and regional structures based on historical approaches to the services provided. As whole population and individual client services integrate, a more coherent local/regional structure will need to be developed. Cohesive local/regional systems will improve the interface between physical and behavioral health programs, thereby improving health and wellness for all people that DSHS serves. Effective measures to protect health and safety, such as radiation control, EMS, regulation of food safety, and bioterrorism preparedness, depend on coordination of multiple sectors in local and regional systems. A cohesive local/regional structure also will improve DSHS capacity to interface with other key services within the HHSC enterprise.

Service Delivery Integration (SDI) is a business process that integrates the functions and health care policy of several DSHS healthcare delivery programs and is supported by an internet-based automation system. The TDH initiated SDI in response to the 1998 Sunset Management Review and House Bill 2085, 76th Legislature, Regular Session, 1999. The pilots for SDI started in September 2000. The functions of this automation system include screening, referral, eligibility, enrollment, billing, payment, and reporting. Department programs currently included in SDI are Title V of the Social Security Act for Perinatal Health, Family Planning, and Women's Health Laboratory; and Title X of the Public Health Service Act and Title XX of the Social Security Act for Family Planning and Women's Health Laboratory. The SDI provides increased access to an array of services for the entire family through a single client application process for multiple funding sources. Services are recorded, billed, and reimbursed on a fee-for-service basis in the automation system in a one-step process, reducing the administrative burden to the contractor and the program. Reports are aggregated in real time online and are available to the contractor and the program. Reimbursement is provided to contractors within one week.

The number of SDI pilots will expand in FY 2005, and DSHS will conduct an extensive evaluation of the SDI business process to examine its efficiency and effectiveness.

In addition, DSHS is actively involved in cooperative efforts and partnerships with the public and private sectors, combining resources to address common goals more adeptly on behalf of the individuals served. This collaborative approach has proven particularly effective for treating persons with severe mental and emotional disorders as these individuals are often simultaneously facing other stressors such as substance abuse, homelessness, and contact with the criminal or juvenile justice system. The alternative of attending to psychological issues without addressing the other challenges frequently results in poorer treatment outcomes and increased overall costs.

Successful collaborations have improved the treatment of individuals with co-occurring psychiatric and substance use disorders (COPSD). Problematic substance abuse is the most common co-morbid condition among people with a major mental illness, affecting 25 percent of the population.[35] [36] Through coordinated efforts begun in 1997, a full-time COPSD manager has been employed to integrate and coordinate the two service delivery systems. State mental health facilities have also implemented COPSD programs as part of the inpatient treatment program.

The MH system also coordinates with the Texas Interagency Council for the Homeless to improve the outcomes for over 105,000 people in Texas with mental illnesses who become homeless each year. The challenges facing these individuals can be severe with 20 percent considered as chronically homeless, almost a third diagnosed with schizophrenia and other psychotic disorders, and about half diagnosed with a co-occurring substance abuse disorder.[37][38] Recently, the Council has developed an action plan to end chronic homelessness, which is being reviewed through public hearings.

Finally, the MH system teamed with the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOMMI) to coordinate care for persons with mental illness who become involved with the criminal justice system. In 2000, the American Psychiatric Association reported that nearly 20 percent of U.S. prisoners were seriously mentally ill and about five percent of them were actively psychotic at any given time.[39] Collaborative efforts also include the development of jail diversion strategies so that persons with severe mental illness may avoid contact with the criminal justice system where appropriate.

[35] Siegfried, N. “A Review of Comorbidity: Major Mental Illness and Problematic Substance Use.” *Aust N Z J Psychiatry*. 1998 Oct;32(5):707-17.
[36] TDMHMR, “CARE database: Unique Outpatient Clients Served FY 2003.” September 2003.
[37] TDMHMR, “CARE database: Unique Outpatient Clients Served FY 2003.” September 2003.
[38] Burt, M., “Practical Methods of Counting Homeless People.” Urban Institute, New York. 1999.
[39] Hearing before the Subcommittee on Crime, of the Committee on Judiciary, U.S. House of Representatives, 106th Congress. September 2000.

Partnerships have also been developed for the benefit of children and adolescents. The TCOMMI, the Texas Juvenile Probation Commission, and the children's mental health service system are working collaboratively to build state capacity to provide MH services to juvenile offenders. Additional partnerships involving the Children's Mental Health System include a partnership with the Department of Assistive and Rehabilitative Services to build a continuum of care for young children with early onset mental health disorders and their families and with the Texas Education Agency to develop school-based MH services.

System Capacity

The Department administers physical and behavioral health services provided by a variety of public and private providers. Challenged to serve consumers better, to be more responsive to local needs, and to make sure that priority health needs are addressed, DSHS will look for innovative ways to strengthen and better coordinate the existing service delivery infrastructure, as well as to expand the system through creative links with other public and private partners.

The system for providing state health services includes DSHS regional offices, Local Mental Health Authorities (LMHAs), local health departments, and other contracted providers. These providers of client-based and whole population services are paid through a variety of city, county, state, federal, and private funds.

Partners of DSHS in the public health system have the common goal to protect, promote, and improve the health of all 21 million people living in Texas. Yet, throughout the state, their specific health needs and priorities vary. A comprehensive and an effective system of public health builds capacity to meet the needs the state's a large and diverse population.

The public health system shares common responsibilities including performing essential public health services and health care safety net services. Public health services address the needs of the whole population in Texas. Health care safety net services meet the health care needs of eligible individuals. The conjunction of public health and health care services form the cornerstone of all public health practice.

Partnerships across the public, private, and nonprofit sectors facilitate the functioning of public health system in Texas. These partnerships enable more people in Texas to access services from the public health system in Texas. The absence of these partnerships would likely diminish the capacity of the public health system to address health across the whole population and among individuals.

To improve alignment of the public and private resources devoted to health in Texas, state leaders convened the Texas State Strategic Health Partnership (TSSHP). Membership of TSSHP includes both public and private organizations that are taking on shared responsibility and accountability for creating a healthier Texas. With a focus on enhancing essential public health services to benefit all Texans and

ensuring the prevention of diseases and illnesses, the TSSHP identified shared priorities for the public health system and worked to apply resources to coordinated action. These priorities are reflected in 12 goals for improved public health.

The prevalence of serious mental illness exceeds the system's capacity to provide treatment. While approximately 433,000 adults in Texas met the DSHS MH priority population in 2003, less than half that number received MH services from the state authority. In addition, approximately 29,000 children and adolescents were served in community-based programs and SMHFs. The number served is estimated at about 20 percent of the potentially eligible population.[40] [41]

People whose mental health needs cannot be met in a community setting may be referred to one of the 10 SMHFs. The role of these facilities has changed over time. Once viewed as long-term placements, these facilities are now used primarily for forensic services, acute care, and crisis stabilization.

Recent changes in the private psychiatric hospital industry have resulted in increased demand for state hospital services. Many communities had private psychiatric beds available to them and contracted their use for treatment of acutely mentally ill individuals. With the continual decline in the availability of private (for-profit and not-for-profit) psychiatric hospital beds, SMHFs are often the only choice for the care of those who require inpatient treatment. Since 1993, the number of available psychiatric hospital beds has decreased 45 percent, from approximately 11,000 to 6,000.[42]

The best available scientific evidence has been used to develop a system of services and supports known collectively as the Resiliency and Disease Management (RDM) Initiative. This initiative has been undertaken to redesign the state MH service delivery system. Specifically, the focus will shift to a disease management approach as required in H.B. 2292.

The RDM initiative targets available resources more efficiently, and proactively identifies and treats populations with chronic conditions based on clinical needs. Emphasizing prevention of acute relapse and complications, the RDM initiative uses evidence-based practice guidelines and patient empowerment strategies such as self-management education. Expected long-term outcomes of implementing RDM include reductions in hospitalizations and reductions in costly negative outcomes such as homelessness and criminal justice involvement. Piloted in four community centers in FY 2004, the RDM initiative will be implemented statewide in FY 2005.

[40] Texas State Data Center and Office of the State Demographer of Rural Sociology, Texas A&M System, http://www./txsdc.tamu.edu (accessed April 2, 2004).
[41] TDMHMR, "CARE database: Unique Outpatient Clients Served FY 2003." September 2003.
[42] TDMHMR. "Report Update for State Mental Health Facilities: Final Draft Report." TDMHMR, Austin, TX. April 2002, pp. 4-5.

Substance abuse and dependence are social and public health problems affecting all sectors of society and are the root cause of many other problems affecting Texans. The nature of these problems is extensive and chronic. Economic costs alone in Texas were estimated to be a $26 billion in 2000 ($16.4 billion for alcohol and $9.5 billion for illegal drugs), which averages to $1,244 for every man, woman and child. However, the economic costs belie the true impact of substance abuse, which is the toll it takes on individuals, families, communities, and society. These costs include disability, reduced productivity, unemployment, poverty, homelessness, and child, spousal, and elder abuse.[43]

In FY 2003, an estimated three million Texans had one or more substance abuse problems requiring some level of help or treatment—almost one-third of those individuals were indigent. In FY 2004, 4.6 percent of the treatment need for adults and 6.6 percent of the treatment need for youth is expected to be met. Trend analysis indicates that use and abuse of alcohol and all drugs will continue to increase.[44]

To effectively address substance abuse in Texas through disease management criteria, several significant enhancements to the needs assessment and data-based, decision- making systems need to be in place. Through the State Data Infrastructure grant to develop infrastructure for collecting and reporting performance measures required by federal grants, DSHS will expand the Behavioral Health Integrated Provider System (BHIPS), a web-based software that integrates tracking, clinical, and billing data into a more comprehensive substance abuse prevention and treatment information system. The Department plans to build a comprehensive youth substance abuse screening and assessment tool, and to add a prevention/intervention functionality to collect data at the event level, which will enable real-time measurement of outcomes, as service providers are performing their work.

Scarce financial resources may be leveraged and the reach of DSHS expanded to meet the needs of more Texans through the successful volunteer involvement, which is good business for state agencies. The HHS system is fortunate to have a long, rich history of civic participation, public engagement, and resource development.

According to a FY 2002 analysis of the volunteer service and community engagement efforts of 18 Texas agencies and organizations, 218,000 Texas volunteers contributed nearly 2.8 million hours of service, with a value exceeding $35 million. In addition, volunteers raised more than $7 million in cash and in-kind contributions benefiting programs and services. In the HHS system, nearly 120,000 volunteers contributed more than 831,000 hours of service to TDoA, TDMHMR,

[43] TCADA, "Statewide Service Delivery Plan." February 2004, p. 13. http://www.tcada.state.tx.us/policy_info/StatewideServiceDeliveryPlan2004.pdf (accessed March 16, 2004).
[44] Ibid. p. 13.

DHS, DPRS, and TDH in FY 2003. That year, $20.8 in donations—service hours, in-kind contributions, and cash donations—were contributed to these agencies.[45]

In summary, the challenges and opportunities for DSHS fall into the broad categories of health status disparities, system integration, and capacity. The consolidation of physical health and behavioral health (mental health and substance abuse) into one department is a significant step toward improving the health of the population of Texas. The Department has set in motion a collection of inventive strategies and partnerships with the goal of becoming an efficient, integrated public health system.

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

DSHS Goal 1: Preparedness and Prevention Services

DSHS will protect and promote the public's health by decreasing health threats and sources of disease.

Community Preparedness

Service Description

The possibility of biological threats, whether naturally occurring or intentionally set, challenges the state in two ways: preparedness and response. Preparedness is the state of adequate preparation for a biological attack, and response is the deployment of necessary resources to address the event, disaster or emergency. These two public health efforts complement one another; neither is effective without the other.

The Department provides statewide public health preparedness planning. The planning enhances both preparedness and responsiveness at the community level. Funding systems from the federal, state, and local levels of government facilitate the existence and maintenance of planning in preparation for and responsiveness to a biological threat.

The Department coordinates the distribution of the Centers for Disease Control and Prevention (CDC) Cooperative Agreement and Health Resources and Services Administration (HRSA) cooperative agreement grant funds to the statewide network

[45] Texas Commission on Volunteerism and Community Service, "Investing in Volunteerism." The RGK Center for Philanthropy and Community Service, a component of the LBJ School of Public Affairs at UT Austin, 2002. http://rgkcenter.utexas.edu/pdf/investing.pdf. (accessed May 25, 2004).

of local health departments and regional health departments for the following purposes:

- Developing, implementing, and evaluating preparedness and response planning;
- Enhancing surveillance, epidemiology, and laboratory capacities, establishing and maintaining the Health Alert Network (HAN), developing and implementing effective risk communication strategies; and
- Assessing, coordinating, delivering, and evaluating workforce development packages to key public health professionals, infectious disease specialists, emergency personnel, and other healthcare providers.
- Supporting and readying hospitals and health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies.

The Department has developed model standards and guidelines to help local jurisdictions prepare emergency response plans with mitigation, preparation, response, and recovery elements. As part of this effort, DSHS developed Annex H of the State Emergency Management Plan, to provide operational policies and procedures, guidelines, and instructions for the integrated management of health and medical services after a disaster.

Finally, emergency response includes the DSHS Texas Critical Incident Stress Management (CISM) Network that is a key component of the Texas Crisis Consortium, which responds to disasters and to the mental health needs of victims and first responders. The Texas CISM network was established in 1992 to assist emergency service personnel, including dispatchers, who have helped with a critical incident such as line-of-duty death, death of a child, or multiple casualty and fatality scenes.

Target Population

Community preparedness serves the entire Texas population. First responders at state and local levels—including firefighters, EMS workers, paramedics, nurses, volunteers, and law enforcement officers—are the primary audience for these training programs.

Disease Control and Prevention

Service Description

Preventing and controlling the incidence and prevalence of disease are addressed through DSHS support for education and risk reduction. Services include

surveillance activities, prevention, and control activities. Surveillance provides the means to monitor health trends:

- Immunization rates;
- Animal vaccination rates; and
- Incidences of diseases such as HIV, sexually transmitted diseases (STD), and tuberculosis (TB).

Prevention activities use these data to target populations at risk for diseases and injuries. Disease control activities help to prevent the spread of disease.

The immunization activities of DSHS improve the quality of life and life expectancy by achieving and maintaining an environment free of vaccine-preventable diseases. Vaccines are a cost-effective public health disease-control measure. Provider and community education campaigns enhance awareness of vaccine-preventable diseases and the importance of immunizations.

Zoonosis control services protect the public's health. Services include the operation of surveillance system for zoonotic diseases and the typing of rabies variants; assistance to communities to conduct zoonotic disease investigations; and the development of effective detection strategies for plague, rabies, and other zoonotic diseases, such as West Nile virus.

The HIV prevention services at DSHS include Health Education and Risk Reduction (HERR), Prevention Counseling and Partner Elicitation (PCPE), and public information.[46] The goal of the HERR component of prevention is to educate persons at "high-risk" for HIV about disease transmission, to assist them in establishing realistic and personalized risk reduction plans, and to provide them with the skills and practice of these skills necessary to prevent transmission of HIV. The Department provides PCPE services throughout Texas by contracting with local health departments and community-based organizations. The focus of prevention counseling is on developing prevention goals and strategies with the client rather than simply providing information. The distribution of public information assists communities and individuals informed about the current trends in HIV prevention and control. In addition, other significant HIV activities include early diagnosis, treatment, provision of medications, and community-based clinical and social services.

Efforts to prevent and control TB include the provision of guidance and support to local health departments on how to conduct targeted testing, perform contact investigations, and conduct outbreak investigations. The TB activities include working with partners and community-based organizations to establish TB screening programs that target high-risk populations in areas with a high prevalence of TB, and educate the public on how to prevent TB.

[46] TDH, "HIV/STD Annual Report 2002." http://www.tdh.state.tx.us/hivstd/legislature/2002.pdf (accessed April 27, 2004).

The registry for Infectious Disease Epidemiology and Surveillance (IDEAS) tracks trends in infectious disease incidence, detects and responds to outbreaks of infectious diseases and newly emerging infectious diseases, and identifies high risk populations.

Community health interventions promote health and prevent incidences of chronic disease. Specific activities include educating individuals on healthy life choices (e.g., physical exercise and dietary habits), community outreach, and clinical preventive services. Specific chronic diseases addressed include: cardiovascular disease, cancer, diabetes, Alzheimer's disease, and arthritis. To address these diseases, DSHS engages in the following activities:

- Surveillance and evaluation;
- Community and policy development;
- Health care improvement;
- Health education and community outreach; and
- Prevention interventions targeted for reducing tobacco use, improving nutrition, and increasing physical exercise.

Target Population

The DSHS activities for controlling and preventing the spread of infectious and chronic diseases target the whole population of Texas, including public and private providers and specific populations at increased disease risk.

Kidney Health Care

Service Description

The Kidney Health Care (KHC) program provides medical, drug, and transportation services to persons suffering from end-stage renal disease (ESRD). Medical services (dialysis and access surgery) are provided through contractual agreements with hospitals, dialysis facilities, and physicians. The program provides payment for covered outpatient drugs, medical services, dialysis services, access surgery, reimbursement for travel to ESRD services, and premium payments for eligible Medicare recipients. Client caseload growth and increased expenditures will exceed the available resources in FYs 2004 and 2005, necessitating a reduction in client services.

Target Population

The Kidney Health Care program serves Texans with ESRD.

Laboratory Support

Service Description

The function of laboratory support at DSHS is to provide the residents of Texas and other customers with analytical, reference, research, training, and educational services.

Laboratory support includes the following services:

- Providing analytical testing and screening services for children and newborns;
- The Women's Health Laboratory provides specialty services for preventive women's health and infectious disease screening, and serves as a resource for the education and training of laboratory professionals;
- Providing diagnostic, reference, and surveillance testing for physicians, hospitals, reference laboratories, and DSHS programs in the sciences of microbiology;
- Providing analytical chemistry support to the U.S. Environmental Protection Agency Safe Drinking Water Program and to other programs supporting public health environmental programs;
- Providing quality assurance and oversight to all laboratory testing;
- Certifying milk testing; and
- Serving in the Preparedness Laboratory Response Network.

Target Population

The laboratory services of DSHS exist to serve all Texans.

DSHS Goal 1 Trends and Initiatives

Preparedness Training

In FY 2004, the Department conducted a series of regional tabletop and functional exercises to test and evaluate the planning efforts for regional preparedness. Coordinated by the community preparedness staff at DSHS, the National Emergency Response and Rescue Training Center, and the Texas Engineering Extension Service. These exercises involved a variety of participants, including councils of governments (COGs), local health departments, hospitals, local emergency management coordinators, the Metropolitan Medical Response System city coordinators, and local officials. The results of the exercises provided information to assess how well the preparedness response system worked.

In the future, DSHS will continue to provide a wide array of training to first responders throughout the state on such topics as critical incident stress management, emergency response plan development and mass casualty exercise design. An increased level of public health preparedness at the community level will

require more dialogue with the key stakeholders, such as the DSHS emergency management, the COGs, the Metropolitan Medical Response System cities, local public health departments, public health regional offices, and other government agencies.

A coordinated and unified methodology is also needed to further public health preparedness regional planning, mitigation, preparedness, response, and recovery initiatives. Some of these partners include U.S. Department of Homeland Security, the Federal Emergency Management Association and several state agencies, Metropolitan Medical Response System cities and local communities.

Increasing Immunization Rates

The purpose of health promotion activities at DSHS is to prevent disease in an effort to support healthy lives. Trends in immunization rates have prompted DSHS to implement health promotion campaigns.

According to the 2002 National Immunization Survey, Texas ranked 45th among U.S. states for the immunization of children 19-35 months.[47] The Department implemented a variety of activities to enhance awareness of vaccine-preventable diseases and the importance of immunizations. The Department promotes immunizations through activities that educate parents, physicians, and other providers about the benefits of vaccination, the importance of accurate vaccination records, and the importance of the state's immunization registry.

A Pertussis Media Campaign was launched by DSHS to focus on reaching Hispanic parents in areas where children have died because of the disease. A campaign to promote the Texas Vaccines for Children program was launched in El Paso, Corpus Christi, Rio Grande Valley, San Antonio, and Houston.

The Department established a statewide immunization partnership that included public health professionals, medical professionals, the insurance industry including managed care, and members of the general public to plan a coordinated effort directed at improving vaccine coverage levels. The outcome of this work was *Immunizing Texas: A State Plan to Increase Immunization Rates in Texas*, a report identifying factors associated with low immunization rates and recommendations for actions to increase the rates.

Legislation from the 78th Regular Session, including Rider 35 in Article II of the General Appropriations Act and Senate Bill 486, further supported the Department's continued immunization promotion activities to increase public awareness of the need for early childhood immunizations. These activities include DSHS collaborating with HHS agencies to educate Texas families, who receive health and human services, about the importance of immunizations.

[47] TDH, "Texas Department of Health Functional Review." September 2003.

Prevention of Obesity

The increasing prevalence of obese and overweight children and adults is a serious concern for Texas. One out of every four adult Texans is obese, while six out of ten are at an unhealthy weight (overweight or obese). In Texas, 14 percent of high school students were overweight or obese in 2001. Being overweight increases a person's risk of heart disease, stroke, high blood pressure, Type 2 diabetes, certain cancers, and other serious medical conditions that impact quality of life and have substantial economic consequences for our healthcare system. The economic costs of overweight and obesity in Texas during 2001 were an estimated $10.5 billion.[48] This includes both direct healthcare costs and indirect costs for lost productivity due to illness and death. If the trend in increasing prevalence of overweight and obesity persists, the annual costs associated with excess weight might reach $39 billion in Texas by the year 2040.[49]

A major effort to address obesity in Texas was the establishment by DSHS of the Statewide Obesity Taskforce. The Taskforce developed the Strategic Plan for the Prevention of Obesity in Texas that communicates strategies for reducing obesity among Texans.

The department also established the Nutrition and Physical Activity Workgroup (NUPAWG) to coordinated activities across programs for reducing obesity and increasing physical activity among the Texas population. The Workgroup's effort focus on creating an environment that supports health dietary and physical activity habits.

Providing Kidney Health Care Services

From FY 1993 to FY 2003, approved applicants for the Kidney Health Care (KHC) services increased by 53 percent, from 3,485 to 5,339. Of the total clients in FY 2003, 35 percent were age 65 or over, 64 percent were ages 21-64, and less than 1 percent were 20 years or younger. [50]

In FY 2003, the incident rate for the KHC program was 245 per million. African Americans had the highest incidence rate by ethnicity at 546 per million. In fact, the incidence rate for African Americans was more than twice the rate for the general population and four times higher than the rate for Anglos.[51]

[48] TDH, "Accent on Health: Texas Department of Health Offers Five Lifesavers for New Year." http://www.tdh.state.tx.us/news/ac122203.htm (accessed on June 7, 2004).
[49] TDH, "Immigrant Health Care." http://www.tdh.state.tx.us/commissioner/powerpoint/immigrant%2D050204.ppt (accessed June 7, 2004).
[50] TDH, "Kidney Health Care 2003 Annual Report." http://www.tdh.state.tx.us/Kidney/2003ar/default.htm (accessed June 3, 2004).
[51] Ibid.

The KHC services provide financial assistance to or on behalf of eligible patients in Texas with End-Stage Renal Disease (ESRD). Financial assistance includes the following:

- Payment to participating pharmacy providers for drugs used in the treatment of ESRD;
- Reimbursement to patients for ESRD-related travel;[52]
- Payment to participating dialysis facilities and hospitals for dialysis services; and
- Payment to surgeons, anesthesiologists, and hospital or surgical centers for allowable medical services necessary for access surgery for KHC recipient.

Other efforts include the provision of training for participating dialysis providers representing approximately 300 KHC facilities. Training covers how to submit KHC applications, travel reports, and patient updates using the automated ASKIT-Web system. The implementation of the ASKIT online claims submission system has automated and streamlined the processing of medical claims billing.

Growth of Laboratory Services

Growth in the population of Texas will be accompanied by a growth in use of and need for laboratory services from DSHS. In FY 2003, the laboratory produced about 16 million work-time units in providing testing services. A work-time unit equals the number of minutes of actual testing time required to produce a reportable result. These services provide a bioterrorism protocol, biochemistry and genetic testing (i.e., newborn screening, clinical chemistry, prenatal testing, and DNA diagnosis), microbiological testing, and environmental sciences.

DSHS Goal 2: Community Health Services

DSHS will improve the health of children, women, families, and individuals, and enhance the capacity of communities to deliver health care services.

Nutrition Services

Service Description

The Department administers three nutrition programs. They are the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); the Farmers' Market Nutrition Program (FMNP); and the Public Health Nutrition Program (PHN).

[52] As a result of H.B. 2292, 78th Legislature, Regular Session, responsibility for transportation services at the Texas Department of Health (TDH) and the Texas Health and Human Services Commission (HHSC) were transferred to the Texas Department of Transportation (TXDOT) effective September 1, 2003. Currently, KHC is continuing to process travel claims for this benefit under an HHSC Interagency Agreement with TXDOT.

The WIC program is primarily administered through contracts with local health departments, cities, counties, hospital districts, hospitals, community action agencies, and other non-profit entities. Women, infants, and children participating in the WIC Program receive nutrition education, breastfeeding support, referrals to healthcare, and nutritious supplemental foods. Some WIC agencies provide immunizations free of charge to WIC clients. The WIC nutrition services are intended to be an adjunct to good health care during the critical times of a child's growth and development, to prevent health problems such as substance abuse, and to improve consumers' health status. The WIC program strives to achieve a positive change in dietary habits with the goal that this change will continue after participation in the program has ceased.

The FMNP is administered through contracts with farmers' markets across the state. The WIC clients receive coupons redeemable at farmers' markets for fresh fruit and vegetables. Through the FMNP, DSHS promotes healthy eating.

The PHN Program collaborates with statewide partners to plan, implement, and evaluate community-based interventions to prevent obesity through healthy eating and physical activity. The program administers the obesity prevention grant from the CDC, monitors nutritional/health status of population, identifies nutrition problems, and provides training, technical assistance, and coalition-building for health professionals. The PHN program is a population-based direct service delivery program.

Target Population

The WIC program and the FMNP provide services to a caseload approaching 1 million pregnant, breastfeeding, and postpartum women, and children under 5 years old who have nutrition-related problems. The PHN program works with communities throughout the state.

Women's Health

Service Description

The Family Planning Program administers and facilitates statewide, coordinated delivery of preventive, comprehensive healthcare services to low-income women and men in order to reduce unintended pregnancies, improve health status, and positively affect future pregnancy outcomes. The program also funds a variety of population-based and infrastructure-building activities such as providing education and early intervention services to adolescent males at risk of becoming fathers, and promoting coordinated agency strategies for teen pregnancy prevention.

The Male Involvement Program at DSHS provides direct services to inform, educate, and empower young men about health issues, particularly prevention of HIV, STDs, and pregnancy. These services include individualized health promotion, education,

and referral. Contractors assess healthcare access to link individuals needing community and personal health services to providers.

The Department administers the Breast and Cervical Cancer Control Program, a federally funded grant program intended to reduce breast and cervical cancer. The purpose of the program is to assure statewide delivery of breast and cervical cancer screening, diagnostic services, case management, and surveillance services to women who are low-income and uninsured. A variety of services are provided on a contract basis:

- Clinical breast examinations;
- Mammograms;
- Pap tests;
- Pelvic examinations for cervical cancer screening; and
- Diagnostic and case management services for women with abnormal test results, such as dysplasia, a pre-malignant or pre-cancerous change to cells in the cervix.

Contractors include local and regional health departments, community health centers, hospitals, family planning agencies, and academic institutions serving women. Contractors are responsible for coordinating the presumptive eligibility process for women diagnosed with a breast or cervical cancer who are potentially eligible for Medicaid under the Breast and Cervical Cancer Treatment Act.

The Department is responsible for implementing perinatal systems legislation and for promoting efforts to address factors that have an impact on perinatal outcomes. It also administers the Comprehensive Women's Health Initiative, funded by the Health Resources and Services Administration, to develop state and local systems development to help assure low-income women have access to comprehensive health care services.

Prenatal care is provided by DSHS. The Department provides educational and counseling services on maintaining a health pregnancy. In addition, referrals are provided as needed for medical care.

Target Population

The Department works with Texas communities to improve, protect, and promote the health of Texas women and their families. Populations include low-income women, men, and adolescents regardless of their age, sex, marital status, number of children, method of birth control, handicap, religion, income, color, ethnicity, or national origin.

Children's Health

Service Description

Direct services to address children's health include provision of comprehensive and preventive healthcare through Newborn Hearing Screens, Social Security Act Title V Child Health Program, Case Management for Children and Pregnant Women, School Health, Oral Health, and Genetics. Activities range from designing and implementing federally mandated outreach materials to educate and train parents, childcare providers, and early childhood professionals on health and safety issues.

The Children with Special Health Care Needs (CSHCN) program operates the state CSHCN medical services program (a health care safety net for Texans) that provides medical, dental, and case management services to children who have a chronic physical or developmental condition. Program operations include eligibility determination, policy development, and claims processing. The CSHCN staff performs the mandated functions of Title V, Social Security Act, including outreach, infrastructure assessment and building, and population-based services such as public education and case management.

The Newborn Screening Case Management program provides follow-up of testing for all infants born in Texas for five disorders: phenylketonuria (PKU), galactosemia, congenital hypothyroidism, hemoglobinopathies, and congenital adrenal hyperplasia. The program assures identification and follow-up of all abnormal test results. Early identification and treatment of these disorders can prevent mental retardation, growth problems, or death. Newborn Screening monitors abnormal results of the five diseases and syndromes screened at birth in Texas.

The Social Security Act Title V Child Health Program provides population-based services including programs that screen Texas children for health needs related to vision and hearing, spinal abnormalities, newborn hearing loss, and newborn diseases. Additionally, children's health programs promote adolescent health, car seat safety, abstinence in teens, and fluoridation of drinking water supplies across Texas.

The Case Management for Children and Pregnant Women program provides training to approved case management providers. Central office staff issues certificates to those in attendance and eligible to provide case management services in accordance with rule and policy. Direct case management services are delivered by regional staff across the state to children with special health care needs and their families, and to children and pregnant women.

School Health, via the Texas School Health Network and the School Nurse Consultants, promotes coordinated school health programming through the training, technical assistance, and development of local school health advisory councils. Staff provides technical assistance to communities seeking to enhance health

services available in schools. Funding to establish school-based health centers is available also.

The DSHS Oral Health program performs dental services and provides technical assistance for community water fluoridation.

Genetics program contracts for direct genetic services and population-based genetic projects. Genetics staff educates healthcare providers, consumers, and the public about the benefits of genetic services.

Effective May 1, 2004, DSHS childhood wellness initiatives funded through several federal grants were consolidated at HHSC. These initiatives focus on strengthening infrastructure and education on health and safety issues relevant to early childhood professionals.

Target Population

The Department is responsible for administering and managing a variety of preventive health, safety, and health care programs that serve children and their families in Texas. Activities range from direct services to enabling and population-based services.

Primary Health Care

Service Description

The Primary Health Care (PHC) Program at DSHS pays health care providers to provide access to primary health care services for those individuals who are unable to access the same care through other funding sources or programs. These services must include the six priority diagnosis and treatment services: emergency services; family planning services; preventive health services, including immunizations; health education; and laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services. Other services may include nutrition services, health screening, home health care, dental care, transportation services, prescription drugs, devices, durable supplies, environmental health services, podiatry services, and social services. Services are provided only through those health care providers who have contracted with TDH to provide PHC Contracts Program services. Contractors annually assess their community's top health issues to target with PHC funding. In FY 2004, the program served 134 counties through 56 contractors.

Target Population

The program serves Texas residents at or below 150 percent of Federal Poverty Level who are not eligible for other programs that provide the same services.

Community Mental Health Services

Service Description

Mental health services are targeted to adults diagnosed with serious mental illnesses and children and adolescents with serious emotional disorders. Community MH services are administered though LMHAs. These LMHAs implement service management and oversight in each local service area, ensuring the delivery of services. Required community-based services are defined in the Texas Health and Safety Code Section 534.053, listed as follows:

- 24-hour emergency screening and rapid crisis stabilization services;
- Community-based crisis residential services or hospitalization;
- Community-based assessments, including diagnosis services, evaluation services, and the development of interdisciplinary treatment plans;
- Family support services include respite care, training, and flexible support for the families of children and adolescents;
- Case management services;
- Medication-related services, including prescribing of medication, medication clinics, laboratory monitoring of medications, and education on medication and mental health maintenance; and
- Psychosocial rehabilitation programs, including social support activities, independent living skills, vocational training, and skills training for children and adolescents to learn problem solving, anger management, and social skills.

The statute further specifies that, to the extent resources are available, the following services should also be provided:

- Ensuring that the services listed in this section are available for children, including adolescents, as well as adults, in each service area;
- Emphasizing early intervention services for children, including adolescents, who meet the Department's definition of being at high risk of developing severe emotional disturbances or severe mental illnesses; and
- Ensuring that services listed in this section are available for defendants required to submit to mental health treatment under Article 17.032 or Section 5(a) or 11(d), Article 42.12, Code of Criminal Procedure.

Through performance contracts with state mental health authorities, requirements to deliver some of these services using evidence-based models have been established. These models include Assertive Community Treatment, Supported Employment, Supported Housing, and Flexible Community Supports for children and their families.

Target Population[53]

The Adult Mental Health priority population consists of: Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment. As part of the Resiliency and Disease Management Initiative, services will be targeted based on clinical need. People will be authorized for those services that have been demonstrated to produce good outcomes for those with similar clinical profiles. All people in crisis will receive services to stabilize the crisis. Those with schizophrenia, bi-polar disorder or clinically severe depression will be targeted for intensive and ongoing services using a disease management approach.

The Children's Mental Health Priority Population consists of: Children ages 3-17 with a diagnosis of mental illness who exhibit serious emotional, behavioral or mental disorders and who:

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

Substance Abuse Services

Service Description

A continuum of evidence-based services address the substance abuse services needs of Texans. In the public sector, most services are available through community organizations that contract with the state for federal Substance Abuse Prevention and Treatment Block Grant funds.

The service continuum begins with the universal and selective strategies for prevention and becomes more individualized as it moves into the indicated prevention strategies that are identified as intervention. After intensive treatment, less intensive services are targeted to support relapse reduction activities and recovery maintenance. The intent is to make an array of services available so that individuals and families can access care most appropriate to their specific needs when and where required.

[53] The heading “Target Population” here refers to the portion of the Texas population that is eligible to receive services from the state. For mental health services, the term “priority population” as defined in Section 531.00(f) of the Texas Health and Safety Code, Title 7, and which is identified in the long-range plan of DSHS, is the term used to refer to persons eligible to receive mental health services. The mental health “target population” refers to a subset of the priority population for which the Texas Legislature has targeted appropriated funds.

Youth who are showing early warning signs of substance abuse and associated behaviors need access to intervention programs where they can receive more intensive services designed to prevent the onset of substance dependence. Outreach, screening, assessment and referral services identify people with substance abuse problems, evaluate their needs and preferences, and link them with appropriate treatment and support services. These services are provided in conjunction with focused, short-term interventions to motivate and prepare individuals for treatment or self-directed change in behavior when more intensive treatment is not indicated. The HIV outreach programs develop and implement disease prevention, risk reduction and treatment persuasion strategies for people whose lifestyles revolve around drug use. The HIV early intervention programs provide case management to meet the needs of identified substance abusers that are also infected with HIV.

The service continuum includes a range of treatment services to fit individual needs. The challenge is to connect individuals in need to care that is appropriate in intensity and duration. Some people enter the system through medically supervised detoxification programs in which they are physically stabilized and prepared for further treatment. Residential detoxification and outpatient ambulatory detoxification are also appropriate interventions for some individuals. Others may not need detoxification and may directly enter into residential and outpatient treatments during which they can examine the impact of substance abuse on their lives and develop skills necessary to achieve and maintain recovery.

Recovery maintenance helps people integrate the cognitive and behavioral skills learned during treatment to achieve a long-term change in lifestyle. In recovery maintenance, people who are completing an episode of treatment receive continuing care, such as low intensity outpatient counseling and case management services, which keeps them connected with the treatment system while they learn to rely on individual and community-based support systems to sustain recovery. A critical element of recovery maintenance is relapse reduction, which helps clients anticipate problems they are likely to confront, identify patterns of behavior that signal relapse, and develop effective coping strategies. These services can be provided through continuing care, but they are also appropriate for people who previously have completed treatment and need brief intervention to maintain a course of recovery. Other brief interventions also are used to help people manage stressful life situations and maintain recovery.

The treatment continuum includes specialized services for women. Contractors are required to provide priority admission and services to women who are using intravenous drugs and who are pregnant or parenting. These women have special needs, and their childcare responsibilities are often an additional barrier to services. Programs with enhanced support services help women address complex issues and develop effective parenting skills, so they may achieve a stable recovery. Because the family is involved and affected by substance abuse, services for family members of a person with a substance abuse problem are essential. Treatment

services for the family of a substance abuser and any goal-oriented strategies designed to support recovery maintenance include basic access by family members and significant others.

Target Population

Substance abuse treatment and intervention services at DSHS serve the adult and youth populations that are identified as having or showing signs of a substance abuse problem. Priority risk groups are specified in state and federal law. Clients eligible for treatment must meet the DSM-IV criteria for substance abuse or dependence and be medically indigent. The clients eligible for treatment are by definition "those with the greatest needs." Clients served are the most vulnerable and typically present with multiple complex problems. They are often more physically ill, have limited financial resources and often times do not have a stable extended support system of family or friends.

Community Capacity Building

Service Description

The DSHS provides a variety services to develop and enhance the capacities of community clinical services providers and regionalized emergency health care systems in Texas. Increasing the numbers of health care professionals and access to health care services in medically underserved areas of Texas is the purpose of the Federally Qualified Health Center (FQHC) Infrastructure Grants, which provide the resources to assist in the development of new and expansion of existing FQHCs. The J-1 Visa Waiver program places foreign physicians in medically underserved areas. Texas currently has 71 placements. The County Indigent Health Care Program provides technical assistance to counties to establish and maintain indigent health care programs, which provide an array of services. Finally, the Department builds community capacity to ensure the public's safety through EMS/trauma systems across the state.

Target Population

The target populations are both the indigent population and the whole population of Texas.

DSHS Goal 2 Trends and Initiatives

Provision of Nutritional Services

The WIC program's major initiative to enhance client services and improve efficiencies at the state and local level has three components: implementation of an electronic benefits transfer (EBT) system for food delivery; a satellite communications system between the central office and local contractors across the state – a Very Small Aperture Terminal (VSAT); and enhancement/upgrade of the

statewide automation system, the WIC Information Network (WIN). All of these projects will enhance the ability of the local service delivery providers to accommodate more clients and more efficiently.

Successful deployment of EBT and VSAT are critical to free up staff resources for timely development of an enhanced WIN system. There is an external mandate by USDA, WIC's federal grantor, that WIC systems migrate to meet updated USDA functional requirements for systems. Continued successful and optimal operations of WIN is critical for delivery of program food benefits to over 860,000 clients monthly, because there is no other practical way to deliver these services.

Provision of Community-Based Mental Health Services

Mental illness is the leading cause of disability in the United States. This public health challenge becomes even more imperative as suicide; a devastating consequence of untreated or under treated mental illness, is the leading cause of violent death each year, surpassing the number of deaths due to homicide or war.[54] The financial cost of mental illness is estimated at $79 billion each year in the United States. The majority of this amount reflects indirect costs connected to lost productivity from related outcomes such as premature death and incarceration.[55] This knowledge spurs a sense of urgency to treat, prevent, and eventually eliminate the destructive effects of mental health disorders.

This sense of urgency is strengthened by the relatively recent understanding that recovery from serious mental illness is possible. Historically, serious mental illnesses were believed to be chronic, and patients' capacity was expected to deteriorate over time. The goal of services had been to slow the deterioration or to maintain functioning. This prognosis provided the rationale for long-term institutional care and many existing community services. There is now substantial and growing evidence that this long-held belief is not true. Longitudinal studies have demonstrated that recovery from mental illness does occur, and many people diagnosed with serious mental illness appear to recover completely. Even for people who continue to experience symptoms, a recovery of functional capacity is being observed.

Increased awareness of the possibility of recovery has implications for the design and delivery of MH services. Some believe that community services, such as congregate living facilities and day programs, can be replaced by services that support recovery. These services include assistance with development and/or rehabilitation of functional skills and supports in areas such as employment, education, socialization, housing, and financial planning. While many of these services are available outside of MH systems, without specialized focus on the

[54] World Health Organization, "World Report on Violence and Health." 2002, Geneva: World Health Organization.
[55] Rice, D.P. & L.S. Miller, "The economic burden of schizophrenia: Conceptual and methodological issues and cost estimates," In M. Miscarelli, A. Rupp, & N. Sartorius, Eds., Schizophrenia, 1996, pp. 321-334, Chichester, UK: Wiley.

needs of people with serious mental illness, access and utility is often nominal. Developing and implementing services that will support recovery and the development of resiliency is a new goal of public mental health systems.

Research has contributed to the quality and breadth of treatments available and to the possibility of recovery. Scientific and clinical advances are helping the public to understand that mental illnesses are treatable medical conditions. Ongoing studies of recovery predict that more significant developments will be made in treatment and prevention strategies. For children and adolescents, in particular, there have been meaningful advances in research in the past decade. Topics of inquiry include the risks for mental disorders or conditions, the efficacy of mental health treatments, and preventive strategies for youth.

Despite scientific advances, state of the art treatments and services are not widely available. Often clinical practices and service system innovations, which are validated by research, are not fully adopted in MH treatment settings and service systems. This is especially true for children and adolescents.[56] Researchers, policymakers, healthcare providers, and individuals with mental illnesses and their families recognize that translating the scientific breakthroughs into procedures and policies of everyday clinical practice is an urgent, essential, and achievable task.

In an effort to implement breakthroughs in service technology, the public mental health system has developed the Resiliency and Disease Management Initiative (RDM). Clinical guidelines have been developed for the RDM Initiative that are based on the best available scientific evidence.

The RDM Initiative includes disease management concepts. Disease Management began as an outgrowth of managed care, with an eye toward reducing health care costs. The managed care industry noted that persons with chronic illnesses who experienced multiple acute episodes accounted for a disproportionate share of spending, with few positive outcomes. A long-term approach was needed to efficiently manage chronic diseases and maintain health. This approach, disease management, has evolved into a systematic, collaborative method to healthcare delivery that proactively identifies and treats populations with chronic conditions. It emphasizes prevention of acute relapses and complications, utilizing evidence-based practice guidelines and patient empowerment strategies such as self-management education.

The concepts of disease management do not apply as neatly to children with serious emotional disturbances because children are not generally considered to have chronic disorders. However, the goals and intended outcomes are equally relevant for both adults and children. For children with serious emotional disturbances and

[56] Huang, N. L., Hepburn, K.S., & Espiritu, R.C. "To Be or Not To Be…Evidence-Based?". *Data Matters*, Spring/Summer Special Issue (6), 2003. National Technical Assistance Center for Children's Mental Health, Georgetown University. http://gucchd.georgetown.edu/datamatters6.pdf (accessed June 16, 2004).

their families, services offered emphasize the development of resiliency, family support, and skills development.

While these scientific advances and the increasing awareness of mental health issues are encouraging, the public MH system faces significant challenges. Diminishing resources restrict the capacity of the system. During FYs 1981 through 1997, funding administered by state MH agencies nationwide declined more than six percent when adjusted for inflation, according to a report by the National Association of State Mental Health Directors Research Institute, Inc. The report notes that unadjusted state MH agency funding grew at a substantially slower pace than other state priorities including welfare, public health, hospitals, and corrections.[57] While resources have dwindled, there is an increased expectation for public MH systems to serve as the safety net for those who are poor, who are uninsured, or who have depleted their private insurance benefits during an illness.

Another significant trend in state mental health financing is the increasing role Medicaid plays in funding public MH services. Medicaid funds accounted for half of all state and locally administered MH services in FY 2000, up from about one third in FY 1985. States have increased their reliance on Medicaid in order to leverage limited state financial resources to obtain federal funds that help pay for public MH services. Leveraging federal funds through Medicaid increases the available resource base of mental health services, but raises a number of considerations.

Dependence on Medicaid funding reduces the capacity of the state mental health authority to implement the most effective programs and services, limiting the state to the services already approved and included in the Medicaid state plan. While it is possible to make changes to the Medicaid state plan, the process is lengthy and work intensive. Also, advances in service technology outpace Medicaid's capacity to include them as allowable services.

Medicaid's medical orientation limits the range of services for eligible consumers. For example, Medicaid does not cover employment and housing supports, peer counseling, and drop-in centers, or a number of other supports that are considered significant elements in the provision of comprehensive services and supports for people with serious mental illness.

Public systems are intended to serve indigent persons with serious mental illness. Many of these people have not been designated as disabled under the Social Security Administration's programs, and as a result, persons with acute rather than extended psychiatric problems are often ineligible for Medicaid.

[54]Lutterman, T., Hirad, A., & Poindexter, B. "Funding Sources and Expenditures of State Mental Health Agencies," 1999. Alexandria, VA: National Association of State Mental Health Program Directors Research Institute, Inc.

As available state resources are used to provide the state matching portion of Medicaid, the amount available to serve people who are not eligible for Medicaid, and/or to provide services not funded by Medicaid, decreases.

The impact of reduced access to publicly funded MH services is visible in data from the criminal justice system. A study by Harvard University and the University of Massachusetts states that 500,000 people resided in state mental hospitals in 1955; by 1990, that number had dwindled to 90,000. The original intent was that people previously served in institutions would be served in community programs. Yet, of the 2,000 community MH facilities in the U.S. that were supposed to open after 1955, only 789 opened. As a result, there are now nearly five times more mentally ill people in the nation's jails and prisons (nearly 300,000) than in all state hospitals (fewer than 60,000).[58]

A study on *"Indigent Mental Health Services"* (Rider 64 report) published in January 2002 by TDMHMR came to similar conclusions. The report found that indigent clients (those with no insurance) receive fewer services than those who are on Medicaid. It was also found that indigent clients are more likely to be involved in the criminal justice system and have higher rates of substance abuse services than those who were covered by Medicaid. [59]

This circumstance essentially leaves courts, jails, and prisons as treatment centers of last resort. Public funds not spent in the MH system appear to result in more public funds expended in the criminal justice system. This pattern of funding also applies to the juvenile justice system. [60]

Provision of Substance Abuse Services

Alcohol is the state's number one drug problem. Although use has been declining gradually since 1990, alcohol remains the drug of choice for young people and the most widely abused drug among adults. [61] In 2002, 71 percent of Texas secondary students reported they had used alcohol at some point in their lives.[62] Alcohol abuse is an underlying factor in a wide range of health problems including cardiovascular disease; liver, oral, and esophageal cancer; hepatitis; gastrointestinal disorders;

[58] U.S. Department of Justice, "Mental Health Treatment of Inmates and Probationers." Washington, D.C.: U.S. Department of Justice, Office Justice Programs, Bureau of Justice Statistics. July 1999; and U.S. Department of Justice, "Mental Health Treatment in State Prisons, 2000." Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, July 2001.
[59] TDMHMR, "Indigent Mental Health Services, Executive Summary." January 2002. www.mhmr.state.tx.us/centraloffice/behavoralhealthservices/Indigent_Mental_Health_Services_Rider_64.pdf (accessed June 7, 2004).
[60] U.S. Department of Justice, "Mental Health Treatment of Inmates and Probationers." Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, July 1999; and U.S. Department of Justice, "Mental Health Treatment in State Prisons, 2000." (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, July 2001.
[61] Drug Demand Reduction Advisory Committee, "Toward a Drug-Free Texas: A Coordinated Demand Reduction Strategy." January 2003, p. 12.
[62] TCADA, "Texas School Survey of Substance Abuse among Students: Grades 7-12, 2002," May 2003, p. 7.

cirrhosis of the liver; and mental illness. Alcohol use by pregnant women can result in low birth weight and children born with fetal alcohol syndrome.[63] Marijuana remained the most commonly used illicit drug among students with 32 percent of all Texas 7-12 graders in 2002 reporting having smoked marijuana at some point in their lives.[64]

Approximately three million Texans have a substance abuse problem and may need some level of treatment. Of those individuals, approximately one million were indigent (951,840 adults and 85,438 youth age 12 and older). In FY 2003, these treatment programs only met 4.6 percent of the adult need and 6.6 percent of the youth need. Ensuring access to quality substance abuse services continues to be a top priority. Reasonable access within all HHS regions is an important factor that guides the funding allocation methodology and design of the service delivery system.[65] The Department allocates regionally-based funding for services based on population need and service availability.

Initiatives treating people with co-occurring psychiatric and substance use disorders employ research-based methods for increasing service delivery and helping clients achieve remission or stabilization from their disorders. Enhancing competencies for all treatment providers is essential to accommodate the needs of people with co-occurring disorders.

Drug courts offer a cost-effective alternative to incarceration by providing community-based treatment as a condition of probation. Participants receive a coordinated program of treatment and rehabilitation supervised by the judge and managed by a team of criminal justice and treatment professionals. House Bill 2668, enacted in FY 2003, strengthened the drug court movement in Texas and mandated that the Drug Demand Reduction Advisory Committee at DSHS take a lead role in ensuring that judges and prosecutors are advised of changes in the law and available resources, including substance abuse and ancillary services.

In FY 2005, funded substance abuse treatment providers will use new disease management criteria, or placement criteria, to guide placement of clients in the appropriate intensity and duration of treatment. Based on the severity of issues identified during assessment, each client will have defined services. Providers will receive feedback about the appropriate placement and transition of clients through the continuum of care. The implementation of a utilization monitoring system will ensure effective movement through the treatment continuum.

Finally, addressing substance abuse needs requires continued efforts to address the stigma of substance abuse as it relates to a whole host of social and other factors.

[63] TDH, “The Health of Texas: Texas State Strategic Health Plan, Part I.” July 2002, p. 25.
[64] TCADA, “Texas School Survey of Substance Abuse among Students: Grades 7-12, 2002.” May 2003, p. 7.
[65] TCADA, “Statewide Service Delivery Plan.” February 1, 2004.

Reduction of Tobacco Use

More than one of every five Texas adults, 20 percent, currently smoke. Tobacco use is the single largest cause of preventable death and disease in Texas. Almost 60,000 youth in Texas become daily smokers each year, and 20,000 of them will ultimately die from smoking.[66]

The Department has implemented a variety of initiatives to prevent the tobacco use. One initiative was "Worth It?", a public awareness education campaign about tobacco prevention and the Texas Tobacco Law for teens (13-17 years old) and adults. The Texas Department of Public Safety (DPS) has partnered with the Department to expand efforts statewide by displaying educational messages and showing public service announcements about the Texas Tobacco Law in DPS offices. Also, the Department implemented a comprehensive tobacco program in some Texas counties. Harris, Fort Bend, Montgomery, and Jefferson counties, which have approximately 20 percent of the Texas population, demonstrated a 36 percent reduction in 6th –12th grade tobacco use (approximately 55,000 fewer youth tobacco users) and a 19 percent reduction in adult smokers (approximately 90,000 fewer adult smokers). Interventions included community/school programs, media, enforcement of tobacco laws, and implementation of cessation resources.

Optimization of Health Care Systems

The Department convened a workgroup comprising 16 key local primary care stakeholders from across the state, to examine whether changes were needed to streamline and redesign business processes and systems of the Primary Health Care (PHC) Program service delivery. The group did not recommend major changes to the program. A subgroup was formed to look at how the current program requirements could be streamlined and how to address opportunities for the Department and contractors to move toward a more integrated primary care model. The workgroup has not finalized recommendations. Additionally, the Department and workgroup agreed that dialogue would continue on how to encourage the sharing of best practices. Video conferencing and routine face-to-face meetings may be utilized. Program staff at DSHS is working with the workgroup.

DSHS Goal 3: Hospital Services

DSHS will promote the recovery and abilities of persons with infectious disease and mental illness who require specialized treatment.

[66] TDH, "Tobacco Prevention and Control, Strategic Plan 2003-2008." http://www.tdh.state.tx.us/otpc/plan.pdf (accessed May 17, 2004).

State Mental Health Facility Services

Service Description

The State Mental Health Facility (SMHF) system includes nine state hospitals and the Waco Center for Youth. The primary role of SMHF system is to provide inpatient services to persons with serious mental illnesses whose needs are not being met in a community setting. Access is limited to those who do not have any other access to inpatient services because of their indigent status or because psychiatric beds do not exist in the community.

State mental health facilities provide specialized and intensive hospital-based MH services. The service array offered by each SMHF is planned jointly by the SMHF and the Local Mental Health Authorities (LMHAs) within each facility's service area. This system is shaped by forces such as local market conditions including the number of admissions and type of services to be provided. A seamless interaction of facility-based and community-based services is promoted through coordination, collaboration and communication between the two service entities on behalf of the consumer.

The Texas Mental Health Code, the Family Code, and the Code of Criminal Procedure each contain elements relating to admission or commitment of individuals to SMHFs in Texas. Accordingly, TDMHMR rules were adopted to implement these elements. The rule for Mental Health Services—Admission, Continuity, and Discharge (Chapter 412, Subchapter D) provides detailed criteria for various types of admissions to SMHFs.

Target Population[67]

The SMHF only admits a person who has a mental illness and either presents a substantial risk of serious harm to self or others or shows a substantial risk of mental or physical deterioration. The SMHF does not admit a person who requires specialized care not available at the SMHF or who has an unstable medical condition that might require inpatient treatment. Special populations include children and adolescents, physically aggressive patients, persons with mental illness who are deaf, acute and sub-acute patients, and persons with co-occurring psychiatric and substance abuse disorders.

The Waco Center for Youth only admits children ages 10-18 who are diagnosed as emotionally or behaviorally disturbed, who have a history of behavior adjustment problems, and who need a structured treatment program in a residential facility.

[67] The heading "Target Population" here refers to the portion of the Texas population that is eligible to receive services from the state. For mental health services, the term "priority population" as defined in Section 531.00(f) of the Texas Health and Safety Code, Title 7, and which is identified in the long-range plan of DSHS, is the term used to refer to persons eligible to receive mental health services. The mental health "target population" refers to a subset of the priority population for which the Texas Legislature has targeted appropriated funds.

South Texas Healthcare System

Service Description

South Texas Health Care System (STHCS) coordinates, delivers, and supports needed public health services to care for patients with TB and complicating illness. Services include the following:

- Treatment of diabetes and hypertension;
- Pediatrics and women's health;
- Health-related education and research;
- Diagnostics; and
- Outreach to community agencies, for prevention and awareness.

The STHCS operates a public health laboratory to screen for infectious diseases such as TB and to respond to medical emergencies and bioterrorism events.

Target Population

The STHCS provides inpatient and outpatient care and services primarily to indigent patients in the Lower Rio Grande Valley of Texas. The public health laboratory serves STHCS clinical needs and the public health needs of the Texas population for medical emergencies and bioterrorism responses.

Texas Center for Infectious Disease

Service Description

The mission of the Texas Center for Infectious Disease (TCID) is to provide quality medical care and professional education of providers for patients with TB, Hansen's disease (leprosy), and other related infectious diseases. The TCID provides inpatient services for patients requiring long lengths of stay to complete treatment. For surgical services, intensive care, sophisticated diagnostics, advanced therapeutics, and emergency care, TCID contracts with the University of Texas Health Center at Tyler, the University of Texas Health Science Center at San Antonio, and other San Antonio-area providers. Outpatient services are provided to treat patients with tuberculosis and Hansen's disease, and complications and co-morbidities affecting treatment of those diseases.

Target Population

The Texas Center for Infectious Disease serves patients from a variety of circumstances:

- Referrals from other states with an interstate compact with Texas;
- Patients older than age 16 with a diagnosis of TB or Hansen's disease who require hospitalization or specialized services; and
- Referrals from local health departments, private providers, and local courts managing patients with infectious TB and Hansen's disease.

DSHS Goal 3 Trends and Initiatives

Services Provided through State Mental Health Facilities

Once considered long-term treatment facilities, state mental health facility (SMHF) utilization patterns have changed over time. Since 1996, SMHFs have experienced a 55 percent increase in admissions. Lengths of stay of 30 days or longer have decreased significantly. This change in utilization patterns has increased SMHF operating costs.[68]

The provision of specialty services becomes an increasingly significant component of the service array in SMHFs for populations with specialized needs. Without specialized attention, these populations are less likely to benefit from treatment. Statewide specialty services include inpatient maximum-security facility for adolescents and adults, residential services for adolescents with serious psychiatric illness, and specialty services for persons with a mental illness who also have significant hearing impairment.

The interaction of several factors shapes the demand for and utilization of SMHF services. Demand increases in proportion to the general population increase. As the uninsured population increases, demand will increase further.

As effective, evidence-based services—such as Assertive Community Treatment (ACT), Supported Housing, or Supported Employment—increase in the community, the need for SMHF services should diminish. Other factors likely to reduce the need for inpatient services include the continuing use of new generation, anti-psychotic medications and new technologies such as telemedicine and teleconferencing.

Maintenance of adequate infrastructure is necessary for providing SMHF services. For several years, resources have been limited for facility infrastructure maintenance. This has resulted in a backlog of deferred maintenance as evidenced by data contained in the TDMHMR Computer Aided Facility Management (CAFM)

[68] TDMHMR, Report Update for State Mental Health Facilities (draft), 2004. http://www.mhmr.state.tx.us/CentralOffice/ProgramStatisticsPlanning/SMHFDraft04-05.pdf (accessed June 21, 2004).

system and by data from external benchmarks. Currently for SMHFs, CAFM's Capital Assets Planning System includes approximately $90 million of critical maintenance needs (system repair and replacement). Maintenance needs are prioritized, with the highest priority given to project addressing Life Safety Code issues.

The 2004-05 General Appropriations Act (Article II, H.B. 1, 78th Legislature, Regular Session, 2003) included a rider requiring a study of SMHF closure and consolidations during the 2004-2005 biennium. The Commission will provide a report with site-specific recommendations on closures and consolidations when the 2006-2007 Legislative Appropriations Request is submitted to the Legislature.

Future Demands on the Texas Center for Infectious Disease

Several policy issues will impact the future of the Texas Center for Infectious Disease (TCID). The number of indigent people who need access to medical services is growing, increasing the demand for health care services from TCID. Procurement of sufficient health care services will depend on the availability of adequate funding for TCID.

The TCID has the capability to respond to acts of bioterrorism. However, it is the only public facility south of San Antonio performing bioterrorism agent detection in its Biological Safety Laboratory and provides first-line responder with expertise in communicable disease treatment. The Department must assess whether TCID has the capacity to fully serve the southern region of Texas in the event of a bioterrorism event.

DSHS Goal 4: Consumer Protection Services

DSHS will achieve a maximum level of compliance by the regulated community to protect public health and safety.

Regulatory and Enforcement

Service Description

Regulatory services at DSHS include professional, facility, and consumer products and services licensing and standards, along with compliance and enforcement. These services protect the health and safety of consumers. Currently, the regulatory programs license, certify, or regulate 190,000 individuals and 80,000 facilities or entities.

The Department regulates approximately 15,334 heath care facilities:

- Hospitals;
- Birthing centers;

- Ambulatory surgical centers;
- End stage renal disease facilities;
- Special care facilities;
- Abortion facilities;
- Substance abuse facilities;
- Narcotic treatment facilities; and
- Private psychiatric hospitals.

The regulatory functions involve issuing licenses, conducting surveys and complaint investigations, reviewing architectural plans, and developing, maintaining and enforcing rules based upon statutory authority. Many of these facilities participate in the federal Medicare certification program and are regulated under state licensing statutes. The overall goal of DSHS is to monitor health care delivery by regulated health care facilities to assure high quality care to the people of Texas and ensure compliance with licensing standards.

To ensure the availability of prompt and skilled emergency medical care across the state, EMS/trauma systems work to improve the quality of emergency medical care to people in need. In regulatory activities, the Department surveys hospitals for trauma designation and licenses emergency medical personnel and providers. Across the state, emergency medical care is enhanced through the administration of grant programs targeting providers, regional advisory councils, and hospitals.

Eleven independent licensing boards are administratively attached to DSHS. These boards regulate the practices of professions, and board activities are staffed by employees of DSHS. The Department provides all the administrative support for their operation. These independent boards govern these professions:

- Speech language pathologists and audiologists;
- Athletic trainers;
- Marriage and family therapists;
- Licensed professional counselors;
- Social workers;
- Fitters and dispensers of hearing instruments;
- Sex offender treatment providers;
- Perfusionists;
- Orthotics and prosthetics;
- Dieticians; and
- Medical physicists.

Along with the independent boards, DSHS regulates more than 20 occupational programs.

Transcripts of educational courses are analyzed for appropriateness to each field of practice. Another critical part of the eligibility requirements is the satisfactorily passing of a competency examination, either developed in-house under an examination component or through a nationally recognized examination developed by a national test vendor. The Department audits continuing education records to review the types of courses offered and to determine whether the licensees are in compliance.

The Department safeguards the public through a variety of consumer protection services. These services include the promotion of public health and safety through an efficient and effective program of education and enforcement. Environmental health and safety services reduce exposure to consumer, environmental, and occupational hazards. Environmental regulation includes the licensing and monitoring of asbestos, lead, hazardous chemical, and indoor air quality related activities. In addition, the Department regulates the sale of bedding, toys, and playground equipment to keep Texans safe. General sanitation services are critical to consumer safety. The Department licenses, inspects, and investigates consumer complaints relating to youth camps, migrant labor camps, tattoo and body piercing studios, and tanning studios. The DSHS inspects public swimming pools, public lodging, school cafeterias, and day care facilities.

Environmental protection extends to the regulation of radioactive materials. In 1963, Texas entered an agreement with the U.S. Nuclear Regulatory Commission (NRC) whereby the NRC relinquished regulatory authority over most radioactive materials to the state, and Texas was recognized as an Agreement State. The Department must maintain an adequate program to protect public health and safety and remain compatible with the federal NRC program rules. To protect consumers from excessive radiation exposure, DSHS also regulates X-ray machines and services, lasers, and mammography facilities.

The safety of certain food and other products is the responsibility of DSHS. The Department performs regulatory activities to prevent the sale of contaminated, adulterated, and mislabeled foods. To protect consumers in retail food establishments, DSHS permits and inspects good service establishments and retail food stores. Over 15,000 food manufacturers, wholesale food distributors, and food salvagers are regulated to assure safe, properly labeled, and wholesome foods. Meat safety regulation ensures that meat and poultry provided to Texas consumers is derived from healthy animals and prepared in a sanitary manner. Standards for the safety of milk and dairy foods are established to eliminate health threats that are potentially transmitted by these products. The seafood program certifies and inspects mollusk and shellfish shippers, tests tissue samples from fish and seafood harvesting areas, and certifies Texas bay waters for safety. State regulations and standards are closely tied to FDA and USDA to ensure food products are safe and can be sold outside the borders of Texas. Drugs, cosmetics, and medical devices manufacturers, distributors and salvagers are also regulated for consumer protection.

Target Population

Regulatory services at DSHS oversee licensing, enforcement, and compliance with standards and regulations for health care facilities, credentialed professionals, and consumer safety products and services that affect the entire population of Texas.

DSHS Goal 4 Trends and Initiatives

Future Demands for Regulatory Services

The challenge for the future is to manage the growth in licensees and in the needed compliance monitoring with limited resources. As the population increases and new technologies develop, more entities and individuals will be subject to regulatory services. This challenge must be met with continued risk-based compliance monitoring to assure efficient use of the available resources.

DSHS Internal Assessment

DSHS Internal Processes

House Bill 2292 merged the services of public health, mental health, substance abuse, and health care information into DSHS. The design and operation of DSHS will maximize the use of available resources in order to continuously monitor the health risks and address the health service priorities of a growing Texas population. The department begins operation on September 1, 2004.

In order to meet the requirements of H.B. 2292, the DSHS Department Program Management Office (DPMO), made up of legacy agency staff, was established to support the development of the new organization in cooperation with the executive leadership of DSHS. The goal of the DPMO is the creation of an integrated and well-organized DSHS that will facilitate coordination between whole population services and individual client services across the regions and local communities of Texas.

The DPMO set out to develop a structure that promotes opportunities to gain efficiencies by organizing around like-kind business processes or functions. The process of developing the new organization identified multiple opportunities for ways to further integrate physical health, substance abuse, and mental health services in the future. The goals for consolidation:

- Creation of a simple organizational structure with the fewest number of executive organizational structures;
- Organizational structure and systems consistent with other health and human services departments;
- Parallel functions across the organizational structure;

- Promote standardization of processes, policies, and procedures for greater consistency in department operations and services; and
- Provide close structural alignment of healthcare services across physical health, mental health, and substance abuse services.

Under the guidance of the DPMO, department work groups are identifying essential projects to accomplish the transition to an integrated DSHS. There are two basic types of projects that have a direct impact on the consolidation:

- Consolidation projects focus on the changes necessary for State Health Services to be an operating agency on September 1, 2004.
- Optimization projects are those that identify and implement efficiencies across the new department. These may happen before or after September 1, 2004.

DSHS Internal Operations

The executive leadership of DSHS has formulated the organizational structure in a manner consistent with the guidelines established by H.B. 2292. The DSHS executive team is made up of the Commissioner, two Deputy Commissioners in charge of Public Health and Regulatory Services and Behavioral and Community Health Services. In addition to the Chief Operating Officer and the Chief Financial Officer, there are four Assistant Commissioners in charge of Mental Health and Substance Abuse, Family and Community Health Services, Prevention and Preparedness Services, and Regulatory Services (see DSHS organizational chart in Appendix B).

DSHS Internal Strengths and Challenges

A number of strengths emerged from the consolidation of the legacy agencies into DSHS. The Department will create an organizational structure to offer more convenient access to a broader range of quality services that protect the public's health and support their health needs. The DSHS organization will improve coordination for the many partners, providers, and contractors who deliver services and perform functions locally and across the state.

The DSHS needs to develop coherent regional and local structures that will facilitate opportunities to improve access to the widest range of public health and behavioral health services. During the course of the transformation from the legacy agencies to DSHS, there will be a need to empower the dedicated and skilled professionals to serve clients more proficiently, to be more responsive to local needs, and to emphasize individual choice.

The DSHS will use communication planning and management to keep employees engaged and productive during the transformation of the legacy agencies into one department. The transformed system will be client-centered, will use public

resources efficiently, and will focus on results and accountability. There will be continuous striving for DSHS to improve services and manage costs through innovation, deployment of technology-based solutions, and implementation of evidence-based, disease management practices.

A communications roadmap is being developed to ensure consistent and timely communications with all stakeholders through the transition and beyond. The DSHS leadership is committed to holding regular "town-hall" style meetings with staff and stakeholders. In addition, the Commissioner of DSHS sends out a periodic report, "Rounds with the Commissioner," to Department staff. Through this report, the Commissioner discusses agency priorities, organizational changes, and future directions.

DSHS Strategic Priorities

- DSHS will ensure the state's preparedness for bioterrorism and naturally occurring outbreaks by enhancing the capacity of state and local systems to detect and control disease outbreaks, to develop and maintain a trained workforce in effective response systems with tested preparedness plans, and to distribute and deploy state and federal preparedness resources with efficiency and coordination.

- DSHS will effectively communicate the benefits of timely administration of recommended vaccines and simplify access to its immunization resources to better meet the needs of providers, parents, and eligible adults, in order to raise immunization levels for Texas children and to assure appropriate adult immunizations.

- DSHS will work to reduce the state's rising obesity rate and its health consequences through evidence-based strategic actions with its partners in the public health system, with a focus on the health of children.

- DSHS will use the knowledge base of health promotion, the skills of disease prevention, and the tools of disease management to design interventions that touch the most people early in the disease development process and complement the department's health care services for eligible individuals.

- DSHS will develop a more coherent local/regional structure through integration of health, mental health, and substance abuse services, so that the public can benefit from services that are more coordinated, accessible, and responsive to local needs.

- DSHS will continue to seek out and convene partnerships with public, private, not for-profit, volunteer, and academic entities in order to leverage state services, resources, and the expertise for achieving the best health outcomes for the people of Texas.

- DSHS will assess current practices against the benchmarks of high quality and proven outcomes for health programs and health service delivery, and adopt and disseminate successful evidence-based methods and interventions.