

BACKGROUND, PURPOSE AND POLICY RECOMMENDATIONS RELATED TO THE GOVERNOR’S COMMITTEE ON PEOPLE WITH DISABILITIES

Note: This document contains background information and policy recommendations related to the issue area of “Health” only. To access the Committee’s full report which covers ten issue areas, please visit the Committee’s website [here](#).

HEALTH

GOAL

Promote health and wellness among Texans with disabilities through accessible, affordable health care options provided in a range of settings.

Overview

Texans with disabilities can face significant obstacles to health and wellness such as a lack of affordable, accessible care; the rise of chronic diseases, often spurred by unhealthy lifestyles; limited availability of long-term services and supports; and a fragmented approach to the treatment of mental illness.

The Governor’s Committee on People with Disabilities’ Citizen Input Survey demonstrated that health care is one of the most important issues to Texans with disabilities. Paramount among the concerns of Texans with disabilities is access to efficient and quality health care. Ninety percent of survey respondents indicated that access to efficient and quality health care is of “high importance” to them. ¹

Despite the obstacles noted above, some promising practices have emerged in Texas. State policies should foster the improvement of health outcomes for all Texans by encouraging the continuation of these positive trends. Specifically, health policies should be guided by these four principles:

- Increase accessibility and affordability of health care
- Promote personal responsibility for healthy lifestyles
- Encourage long-term services and supports in a range of settings, including in community based settings
- Support early intervention and therapeutic treatments for Texans experiencing mental illness

Background and Purpose: Increase Accessibility and Affordability of Health Care

All people need access to healthcare, but for many people with disabilities, the need can be especially pressing. People with disabilities tend to be in worse health than their peers without disabilities, but they tend to use preventative services at a lower rate, despite their higher prevalence of secondary conditions. Put simply, people with disabilities may have urgent health care needs that sometimes go unaddressed due to barriers to care. These barriers often include lack of appropriate training among health care practitioners, lack of accessible medical facilities and equipment, and stereotypes about disabilities that persist even in health care settings. ²

Even when accessible health care is available, many Texans with disabilities struggle to afford the care they require. While technology and ever-increasing sophistication of medical understandings improve, many Texans are left behind because they remain without viable access to health care.

A few simple examples illustrate the barriers that Texans with disabilities may face to keep them from benefiting from accessible, affordable care.

- A woman knows that her family history puts her at increased risk for breast cancer, so she schedules an appointment for a mammogram to screen for the disease. When she arrives at the doctor's office, she discovers that the X-ray machine is positioned at a height that she cannot reach from her wheelchair. She is unable to benefit from this screening tool.
- A high-school boy with autism attends his annual physical. Because the boy does not make eye contact with the doctor and appears distracted, the doctor addresses many of his comments and questions to the boy's mother while the boy is out of the room. The boy leaves the appointment without a clear understanding of his health and without the opportunity to ask the questions he wanted to ask the doctor.
- A man whose disability prevents him from working is referred by his general practitioner to a specialist for treatment. It turns out that the specialist does not accept Medicaid. The man cannot afford to pay for treatment out of pocket.

At the federal level, the [United States Access Board](#) is currently developing standards [related to medical diagnostic equipment](#). These standards will address access for people with disabilities to examination tables and chairs, x-ray machines, and medical equipment. The Committee encourages support of the [universal design](#) of medical facilities and robust implementation of the Access Board's new standards when they take effect. Further, the Committee supports promoting education among medical service providers about the current legal requirements for accessibility and about disability etiquette, People First language, and other practices that will ensure that Texans with disabilities receive prompt care in a setting that respects their dignity.

Texas has already taken some steps to improve Texans' access to affordable healthcare, including a [major expansion](#) of Medicaid managed care options. Unfortunately, Texas is still the state with the highest uninsured rate in the nation at 24.6 percent. Nearly one in four Texans lacks health coverage. This includes one-third of Texas's working age adults.³ People with disabilities disproportionately bear the burden of being uninsured because too often disability, unemployment, and a lack of medical insurance go hand-in-hand. Some Texans with disabilities who are able to work may find themselves in a catch-22: often their modest wages disqualify them from receiving healthcare through Medicaid, but their employers do not provide health benefits and they cannot afford or do not qualify for private insurance due to a pre-existing condition. For these reasons, the Committee supports health care reform in Texas that would increase the number of insured Texans while maintaining access to quality medical care with a strong emphasis on prevention and individual choice. Further, the Committee supports efforts that will enable small employers in Texas to offer health insurance to their employees.

As we contemplate the question of how to help Texans with disabilities afford health care, it is useful to consider the role that innovation may play in transforming the costs of health care in the coming years. The unsustainable growth rate of United States medical spending dominates almost any discussion of American health care. As a share of our nation's gross domestic product (GDP), spending on health care grows each year and appears to threaten to consume spending allocated for other important services. Some experts have suggested that rather than asking ourselves how to afford health care, we should be asking instead how to make healthcare more affordable. One possible avenue for making health care more affordable may be "[disruptive innovation](#)," a process that couples "cost-reducing technologies with innovative business models to deliver increasingly affordable and accessible products and services."⁴

Recent history includes many examples of disruptive innovations that took a once expensive and complex innovation available only to a select few and placed an affordable version into the hands of the masses. Not so long ago, mainframe and minicomputers were available only to wealthy corporations or universities who could afford to maintain the computer and employ skilled computer scientists and technicians to process jobs. The disruptive innovation of the personal computer (PC) changed all of that. Once the PC established a foothold in the market, improvements to the PC soon followed. The PC became more powerful and improved in functionality over time. Eventually, even the users of expensive mainframe computers found that their needs could be met by PCs. This example illustrates some hallmarks of disruptive innovations: they are usually introduced to the market by new entrants, not established industry giants; they generally start out as an inferior product compared to the product existing customers are already using, but they are simpler, more convenient, and more affordable, and thus appeal to a previously ignored set of customers; and, finally, as the innovation improves over time, it can begin to replace the existing product, even among the most affluent customers.⁵

The question of what disruptive innovations in health care would look like has been discussed in detail in Hwang and Christensen's "[Disruptive Innovation in Health Care Delivery: A Framework for Business-Model Innovation](#)." In essence, the authors propose a regulatory environment that allows for innovation in service-delivery. These innovations would assume a share of the work-load currently being performed by physicians in expensive settings, such as hospitals. Facilitated user-networks, such as those utilized successfully in Weight Watchers and Alcoholics Anonymous, could be expanded to address specific, rules-based portions of health care, allowing for delivery at a lower cost and preserving the role of patient-physician interactions in complicated cases. Technology could be harnessed to simplify and streamline information-sharing and transform our current, fragmented system of care into a coherent system based around satisfying relationships.⁶ Examples of other disruptive innovations that may gain traction in health care and health care delivery are retail clinics, telemedicine, medical tourism, personalized medicine, and point-of-care payments.⁷

Policy Recommendations:

- **Recommendation 5.1:** Support the universal design of medical facilities and examination tables, diagnostic equipment and devices to benefit all people, including people with various types of disabilities.
- **Recommendation 5.2:** Promote education among medical service providers about legal requirements for accessibility of medical facilities, including the use of reasonable accommodations to ensure that Texans with disabilities receive prompt care in a setting that respects their dignity.
- **Recommendation 5.3:** Support health care reform in Texas that would increase the number of insured Texans while maintaining access to quality medical care with a strong emphasis on prevention and individual choice.
- **Recommendation 5.4:** Support efforts to help small employers offer health insurance to their employees.
- **Recommendation 5.5:** Encourage a regulatory environment that allows for “disruptive innovations” in health care delivery that will enhance affordability of health care for all Texans.

Background and Purpose: Promote Personal Responsibility for Healthy Lifestyles: Fighting Obesity and Chronic Disease

Texas is currently facing an obesity crisis that threatens the health and wellness of our citizens and the productivity and financial welfare of our economy. It is not an exaggeration to say that most Texans are overweight; in fact, it is an understatement. The Texas Comptroller of Public Accounts reported in 2011 that 66.7 percent of adult Texans were overweight or obese and that the trend was on the rise.⁸

The obesity crisis comes with a huge price tag. For Texans, obesity means reduced life expectancy, amplified risk for chronic diseases, increased health care costs, and diminished lifetime earnings. The average health care spending for an adult who was obese in 2006 was \$1,429 or almost 42 percent higher than the spending of a normal-weight person.⁹ Estimates suggest that the average lifetime cost of obesity is over half a million dollars for an adult whose obesity began in childhood.¹⁰ For Texas businesses, obesity often means additional health care costs for employers, decreased productivity and increased absenteeism, and a rise in employee disabilities. The Texas Comptroller of Public Accounts reported that obesity costs businesses in Texas an additional \$9.5 billion annually.¹¹ If current trends continue unchecked, the cost of obesity to the Texas economy is estimated to reach \$32.5 billion annually by 2030.¹²

Going hand-in-hand with a rise in obesity in Texas is a rise in chronic diseases, which negatively affect the lives of millions of Texans. In fact, when looking at statistics about those affected by chronic disease, it is sometimes easier to comprehend who is not personally affected, rather than who is. Only 31 percent of Texans do not experience any form of chronic disease.¹³ In Texas, 50 percent of all deaths

per year are caused by heart disease, cancer, or stroke. ¹⁴ Overall, chronic diseases are responsible for between 60 and 70 percent of all deaths in Texas. ¹⁵

As our understanding of the interconnectedness of these chronic diseases grows, our preferred methods of treatment continue to evolve. Conditions like obesity, cardiovascular disease, and diabetes cannot be treated as separate illnesses because the conditions are interconnected. For this reason, the Committee supports Texas's continued effort to integrate its response to chronic disease prevention and care, as exemplified in recent efforts by the Department of State Health Services through the [Health Promotion and Chronic Disease Prevention Section](#).

Behavioral choices, such as how much physical activity a person engages in, whether the person eats well, and whether the person uses tobacco products or consumes excessive amounts of alcohol, all contribute to overall wellness. In fact, the World Health Organization has estimated that if the major behavioral risk factors for chronic diseases were eliminated, more than 40 percent of cancer cases could be prevented and, astonishingly, at least 80 percent of all heart disease, stroke, and type 2 diabetes could be prevented. ¹⁶ Reed Tuckson of the United Health Foundation puts a fine point on it: “[t]here’s no way that this country can possibly afford the medical care costs and consequences of these preventable chronic illnesses [...] We have two freight trains headed directly into each other unless we take action now. [...] People have to be successful at taking accountability for their own health-related decisions.”
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Because behavioral choices play such a critical role in the prevention of chronic diseases, the Committee supports positive, innovative approaches to improvements: technological resources that will enhance Texans' ability to self-monitor chronic health conditions; long-term plans that will increase physical activity and improve nutrition; and community programs that will reduce the incidents of smoking and tobacco use and will reduce incidents of alcoholism.

Policy Recommendations:

- **Recommendation 5.6:** Support integrated initiatives in chronic disease prevention and treatment that promote overall wellness of Texans.
- **Recommendation 5.7:** Invest resources in the continued development of technology that improves individuals' ability to self-monitor chronic health conditions and live independently.
- **Recommendation 5.8:** Establish a long-term plan to develop accessible community-based programs to increase physical activity and improve nutrition throughout the state to reduce chronic disabilities caused by obesity.
- **Recommendation 5.9:** Implement community programs, services and education throughout Texas to promote the cessation of smoking and other tobacco use and to address the need for reduction in potential alcoholism.

Background and Purpose: Encourage Long-term Services and Supports in a Range of Settings

How does a Texan choose where to live? The answer depends on each Texan's needs and personal preferences. Some young people move to urban areas for work or education; parents often look for homes in neighborhoods with good schools; and older Texans may seek retirement homes with a lakefront view. In short, most Texans live in settings that they have chosen to suit their lifestyles.

How does a Texan with a disability choose where to live? The answer should be the same as for anyone else: Texans with disabilities should live in settings that they have chosen to suit their lifestyles. In recent decades, the disability community has seen significant progress toward this goal. There has been steady movement away from the automatic institutionalization of people with disabilities in hospitals or nursing homes and toward home and community-based services (HCBS).

What does it mean to live "in the community?" For some people with disabilities, it means living with family members or a spouse. For others, it means living with friends, roommates, or in a small group home. For many people with disabilities, living in the community is the natural choice and does not require any additional services or supports. Some Texans with disabilities require periodic visits from physical therapists, health practitioners, or personal care attendants and Texans with severe disabilities may require regular assistance with tasks of daily living or regular medical care. These Texans can still live in the community, rather than in an institution, if the services they require can come to them.

When it comes to services for people with disabilities in Texas, where once people had to go to the services, increasingly, the services are now coming to the people. This is good news for several reasons. First, providing services in the community respects the civil right of a person with a disability to choose to live where he or she wants. Second, it means that people have the choice to live with family, friends, or independently in integrated community settings. Third, this trend represents cost-savings for the State of Texas.

Through the [Medicaid](#) program, the state pays for access to services for many, but not all, Texans with disabilities. At first blush it might seem that providing home and community-based services (HCBS), which involves transportation costs for the provider, would be more expensive than providing care in an institution, but a 2009 study by the AARP (formerly known as the American Association of Retired Persons) suggests otherwise. The AARP study demonstrates that "[o]n average, the Medicaid program can provide home and community-based services to three people for the cost of serving one person in a nursing home. Research shows that states that invest in HCBS, over time, slow their rate of Medicaid spending growth, compared to states that remain reliant on nursing homes."¹⁸

Why is providing HCBS less expensive than providing services in an institution? One simple explanation is that most people with disabilities do not require 24-hour care, but that is the kind of care available in most institutions. Another reason is that people who live in their own homes or community settings are generally paying their own rent, utilities, and food expenses, or relying on family members to cover those expenses. In an institution, those expenses are often billed to the state through Medicaid.

Are home and community-based services right for everyone? Well, this is Texas, and Texans like to have choices. The one-size-fits-all practices of institutionalization are over, but one-size-fits-all

assumptions about community-based care will not work either. Some people with disabilities and their families prefer the supported environments of [state supported living centers](#), [intermediate care facilities](#), and nursing homes.

Providing a full spectrum of options for people with disabilities means providing safe, reliable, and affordable institutional options on one end of the spectrum and flexible, community-based options on the other, always with an emphasis on quality. Governor Rick Perry affirmed his commitment to providing Texans with disabilities and their families with a broad spectrum of living choices in [Executive Order 13](#) in 2002. In the Order, the Governor stated that “it is imperative that consumers and their families have a choice from among the broadest range of supports to most effectively meet their needs in their homes, community settings, state facilities or other residential settings.”¹⁹ To that end, the Governor pledged his support of many state initiatives that support community-based options, including the [Promoting Independence Plan](#) and accessible housing initiatives through the [Texas Department of Housing and Community Affairs](#).

The Governor’s Committee encourages the Legislature to continue to take steps that will increase the safety and affordability of care of Texans who reside in institutions while also enhancing opportunities for Texans with disabilities to receive care in their community settings.

Policy Recommendations:

- **Recommendation 5.10:** Increase the safety and affordability of care within institutions, including State Supported Living Centers, State Hospitals, and Intermediate Care Facilities.
- **Recommendation 5.11:** Increase support for home and community-based care for all Texans with disabilities, whether they are recipients of Medicaid or not.
- **Recommendation 5.12:** Allow Medicaid funding to be spent on home and community-based care, such as [Community First Choice](#) options.
- **Recommendation 5.13:** Retool programs and regulations to enable people to access the services they need to live independently without creating financial hardship for the family.

Background and Purpose: Aging-in-Place, the “Medical Home” Model, and Caring for Caregivers

Where would you like to spend your aging years? If your answer is “at home,” you are in a solid majority. More than 80 percent of Americans express a preference for aging in their own homes.²⁰ This preference has given rise to a movement, often referred to as “aging-in-place.” The Committee supports initiatives that will respect the wishes of aging Texans by allowing them to remain in their homes or with family members, rather than in nursing homes or other institutions, if aging-in-place is their preference. Supporting the growing number of aging Texans will require some changes in our health

care delivery system and enhanced support for family members who may also fulfill the role of caregivers.

Texas's population is growing and aging. U.S. Census figures report that Texas had the most population growth of any state in 2011.²¹ At the same time, Texas has a high population of people from the Baby Boom generation, the generation born between 1946 and 1964. In January of 2011 the Baby Boomers began turning 65 at a rate of 10,000 per day and will continue to do so until the year 2030.²² As the existing Texas population ages, our State continues to attract mature members of society from outside the State as well. Several distinct health care needs of the aging population should be addressed as we move forward.

Many Texans will acquire age-related disabilities, requiring particular care in the most accessible setting possible. One of the most pervasive, age-related disabilities affecting aging Texans is Alzheimer's disease. In 2008, Alzheimer's disease surpassed diabetes to become the sixth leading cause of death among U.S. adults age 18 or older.²³ The Council of State Governments reports, "[a]ge is the single greatest risk factor for Alzheimer's disease. Unless something is done to delay the onset or to intervene, researchers predict as many as 16 million Americans will have Alzheimer's disease by 2050."²⁴ The Committee supports statewide efforts to enhance the prevention and treatment of Alzheimer's disease.

Promising practices in health care, particularly for the aging population, focus on the idea of a "[medical home](#)." In the medical home model, patients receive services in their own homes or at an adult day-care center. Doctors, social workers, occupational and physical therapists, and other specialists provide the care and are compensated by fixed monthly rates for each patient. Because the rates are fixed, rather than a fee-for-service, some experts believe providers will have an incentive to encourage overall wellness and will not order unnecessary tests or procedures. The Council of State Governments spoke positively about the possibilities offered by medical homes:

[a]t the core of the medical home is the patient's personal, comprehensive, long-term relationship with a primary care physician and a philosophy of care focused on preventing illness and helping patients take an active role in promoting their own health. The primary care physician and staff act as a home base – or the patient's medical "home" – where the patient can access care during extended hours, patients actively participate in their care, and the medical home coordinates medical care across all health care settings such as hospitals, outpatient facilities and nursing homes.²⁵

Another trend emerging as Texans move into their later years is an increased reliance on family members and friends to provide necessary support and caregiving. According to a recent Gallup Poll, more than one in six American workers also provides care to a family member or friend who is elderly or has a disability.²⁶ This additional, uncompensated caregiving activity cuts into the caregiver's ability to participate in gainful employment. It also takes a toll on the caregiver's health; another Gallup Poll indicated that caregivers have worse emotional and physical health as compared to non-caregivers.²⁷

Service providers are familiar with being asked to do more with less. The Committee hopes that these recommendations will offer ways for Texas health service providers to work smarter, more efficiently, and more affordably.

Policy Recommendations:

- **Recommendation 5.14:** Support ongoing and expedited implementation of the activities outlined in the [2010-2015 Texas State Plan on Alzheimer's Disease](#).
- **Recommendation 5.15:** Explore the use of [telemedicine](#) to assist healthcare practitioners as a tool to serve the increasing numbers of people with disabilities in Texas.
- **Recommendation 5.16:** Explore the use of the medical home model for Texans.
- **Recommendation 5.17:** Promote workplace-friendly policies and practices for those in the workforce who are also acting as long-term caregivers.

Background and Purpose: Mental Health

Texans of all ages and from all walks of life may at some point in their life face mental health challenges. In 2009, the estimated number of adults with serious and persistent mental illness in Texas was almost half a million. [The Department of State Health Services](#) (DSHS), the Texas State agency tasked with improving the physical and mental health of Texans, estimated the figure at 467,226.²⁸ The sheer number of Texans facing mental health challenges requires that lawmakers and officials think strategically about how best to provide much-needed mental health services in a cost-effective way that is accessible to all Texans.

Currently, Texans receive mental health services through private providers and through an array of services through DSHS, ranging from prevention and early identification to residential treatment and in-patient hospitalization. The Committee believes that the people of Texas are best served in settings of their own choosing and supports a broad spectrum of care options for Texans with mental health issues.

Policy Recommendation:

- **Recommendation 5.18:** Support early intervention and therapeutic treatments for Texans experiencing mental illness.

Background and Purpose: Forensic Commitments, Jail Diversion Programs, and Mental Health Courts

Although many people who experience mental illness never encounter the criminal justice system, there are situations in which criminal justice and mental health service delivery do overlap. Texas State Psychiatric Hospitals often house offenders or alleged offenders with mental illness. These hospitals face significant strains on their capacity as they strive to serve two populations: Texans who are criminally admitted and Texans who are civilly admitted. Because most State Psychiatric Hospitals are operating at or above capacity, a spokesperson for the Department of State Health Services summed

up the capacity challenge in this way: “we can’t admit one unless we discharge one, and we have to take into account what’s best for the patient, not just the numbers.”²⁹

This issue of capacity was examined by the [Continuity of Care Task Force](#), convened by DSHS in 2010. The Task Force summarized:

[t]he Texas state psychiatric hospital system is nearing or already over capacity. Lack of sufficient capacity of both inpatient and outpatient treatment resources for individuals with behavioral health disorders is a public health concern in Texas. Significant numbers of Texans are unable to access services for mental illnesses for a variety of reasons. This, in the context of a growing Texas population with the highest percentage of medically uninsured in the nation, signals a convergence of factors impacting all sectors of our state environment.³⁰

Two years later, the situation is much the same. DSHS reports that State mental health hospitals “continue to operate at or above funded capacity, with several hospitals on diversion (triaging patients to hospitals with available beds) on most days. More than 500 patients have been in the hospital for more than a year because they require supports not available in the community.”³¹ One contributing factor to the strain is an uptick in forensic commitments. The number of patients admitted to these hospitals as forensic commitments has increased from 16 percent admission in 2001 to 36 percent in 2008.³² Forensic commitments include two groups of people: first, there are people who have allegedly committed a crime, but because a mental health issue prevents them from understanding the charges brought against them, they are not yet competent to stand trial. These alleged offenders are committed to a State mental health hospital for treatment that may restore their competency and allow them to eventually stand trial. Second, there are people who have been charged with a crime, but were found “not guilty by reason of insanity.” In those cases, the person is not subject to jail time, but may still pose a threat to self or others and may require treatment in a facility. An increase in forensic commitments means a corresponding decrease in each State facility’s capacity to accept civilly committed patients.

Despite significant challenges, there are promising practices emerging in Texas, including the rise of [jail diversion programs](#) and specialty [mental health courts](#). Jail diversion programs are designed to prevent unnecessary detention of people with mental health issues. In the past, when police were called to a situation involving a person with mental illness in crisis, the call often led to an expensive incarceration of the person in crisis.³³ Today, police officers are receiving more training in recognizing the signs of mental illness and in how to diffuse crisis situations. Beginning in 2012, Texas law enforcement officers with peace officer certification are now required to have 40 hours of training in crisis intervention.³⁴ Instead of resorting to incarceration to put an end to a volatile situation, officers are trained to consider other alternatives, including escorting the volatile person to a health care service center or a hospital emergency room, where the person may receive a psychiatric evaluation and a referral to a doctor or State hospital.³⁵ These alternatives represent a cost-savings for the community and also a benefit to the person experiencing mental illness, who may be directed to a service better suited to serve the person’s needs.

Mental health courts are another iteration of programs designed to keep people with mental illness out of serving unnecessary or inappropriate time in jail. Mental health courts are similar to other problem-solving courts, such as domestic violence courts and drug courts, which attempt to address the

underlying issue that may have prompted the criminal behavior. The end result of a case before a mental health court may be a judicially-supervised, community treatment plan for the offender, designed and implemented by court staff and mental health professionals. [Harris](#) and [Bexar](#) Counties are two examples of jurisdictions that have successfully implemented mental health courts.

For the above programs to work, the overlap between mental health service delivery and criminal justice must include community-based programs that will allow people experiencing mental illness to access services before, during, and after their period of need. Programs should focus on treating the individual and allowing for recovery, rather than on criminalizing non-violent behaviors that may be a manifestation of a disability. The Committee supports increased funding for integrated prevention and recovery focused programs that treat alleged offenders and convicted offenders in the most appropriate and therapeutic setting.

Policy Recommendations:

- **Recommendation 5.19:** Encourage a multi-faceted, coordinated plan between State authorities, county jails, and public and private mental health authorities/providers to diagnose and treat offenders with mental illness in the most appropriate, therapeutic setting.
- **Recommendation 5.20:** Encourage the development of programs to facilitate the early identification and diagnoses of mental illnesses and linkages to appropriate and effective treatments.
- **Recommendation 5.21:** Support continued efforts to implement the August 2010 Texas Department of State Health Services Continuity of Care Task Force Report [recommendations](#).
- **Recommendation 5.22:** Support continued implementation of jail diversion programs and specialty mental health courts that prevent expensive incarcerations and allow for Texans with mental illness to receive appropriate treatment in the community.

ENDNOTES

¹ 2012 Texas Governor's Committee Citizens' Input Survey

² National Council on Disabilities. (2009, September 30). *The Current State of Health Care for People with Disabilities*, p.1. Retrieved from the NCD website: <http://www.ncd.gov/publications/2009/Sept302009>

³ Center for Public Policy Priorities. (February 2012) *What Happened and What Work Remains?: Health Care and the 2011 Legislature*, p.1. Retrieved from the CPPP website: http://www.cppp.org/files/3/2012_02_HC_TexasHealthCareMHM_Web.pdf

⁴ Hwang, J. & Christensen, C.M. (2007). *Disruptive Innovation in Health Care Delivery: A Framework for Business-Model Innovation*, p.1329 . Retrieved from the Health Affairs website: <http://content.healthaffairs.org/content/27/5/1329.abstract>

⁵ Ibid, p. 1330-1131

⁶ Ibid, p. 1334-1335

⁷ Glabman, M. (January 2009). *Disruptive Innovations that Will Change Your Life in Health Care*. Retrieved from the Managed Care Magazine website: <http://www.managedcaremag.com/archives/0901/0901.disruptive.html>

⁸ Combs, S. Texas Comptroller of Public Accounts. (2011). *Gaining Costs, Losing Time, 2011 Special Report: The Obesity Crisis in Texas*, p. 1. Retrieved from: <http://www.window.state.tx.us/specialrpt/obesitycost/pdf/GainingCostsLosingTime.pdf>

⁹ Ibid, p. 1

¹⁰ Ibid, p. 1., internal citation omitted

¹¹ Ibid

¹² Ibid, p. 2

¹³ Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey. (2009). Available from Center for Health Statistics at the Texas Department of State Health Services website: <http://www.dshs.state.tx.us/chs/>

¹⁴ Texas Department of State Health Services. (2010). *Texas Chronic Disease Burden Report*, p. 2. Retrieved from: www.dshs.state.tx.us/chronic/pdf/CDBR2010.pdf

¹⁵ Ibid

¹⁶ Ibid

¹⁷ Healy, M. (December 11, 2012). *Health Rankings: USA is Living Longer, but Sicker*. Retrieved from the USA Today website: <http://www.usatoday.com/story/news/nation/2012/12/10/health-rankings-states/1759299/>

¹⁸ AARP Public Policy Institute. (June 2009). *Providing More Long-term Support and Services at Home: Why It's Critical for Health Reform*. Retrieved from: http://www.aarp.org/health/health-care-reform/info-06-2009/fs_hcbs_hcr.html

¹⁹ Executive Order No. 13 (2002), available at <http://governor.state.tx.us/news/executive-order/4431/>

²⁰ Council of State Governments. *Long-term Care*, p. 1, citing Prince Market Research. (August 20, 2007). *Attitudes of Seniors and Baby Boomers on Aging in Place*. Retrieved from: http://www.csg.org/knowledgecenter/docs/TIA_FF_LongTermHealthCare.pdf.

²¹ U.S. Census Bureau. (2011). *Texas Quick Facts*. Retrieved from the U.S. Department of Commerce website: <http://quickfacts.census.gov/qfd/states/48000.html>

²² Pew Research Center (December 29, 2010). *Baby Boomers Retire*. Retrieved from: <http://www.pewresearch.org/daily-number/baby-boomers-retire>.

²³ Minino, M.P.H., A., Xu, M.D., J. & Kochanek, M.A., K. - Division of Vital Statistics (2010, December 9). *Deaths: Preliminary Data for 2008*, Volume 59, Number 2, Retrieved from the Centers for Disease Control and Prevention website: http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_02.pdf), as cited in Cognitive Impairment and Alzheimer's Disease Report from the Council of State Governments, available at www.healthystates.csg.org/NR/rdonlyres/.../AlzheimersTPfinal.pdf, p. 2

²⁴ The Council of State Governments. *Cognitive Impairment and Alzheimer's Disease*, p. 2. Retrieved from: <http://www.healthystates.csg.org/NR/rdonlyres/265E9FFC-18C4-4757-9254-CB6AC771EA46/0/AlzheimersTPfinal.pdf>

²⁵ The Council of State Governments. (November 2010). *State Initiatives in Patient-Centered Medical Homes*, p. 1. Retrieved from the Knowledge Center website: http://knowledgecenter.csg.org/drupal/system/files/CR_FF_Patient_Centered_Homes_0.pdf

²⁶ Cyncar, P. & Mendes, E. (July 26, 2011). *More Than One in Six American Workers Also Act as Caregivers*. Retrieved from the Gallup website: <http://www.gallup.com/poll/148640/One-Six-American-Workers-Act-Caregivers.aspx>

²⁷ The Arc. (June 2011). *Still in the Shadows with Their Future Uncertain: A Report on Family and Individual Needs for Disability Supports*, p. 6. Retrieved from: <http://www.thearc.org/document.doc?id=3672>.

²⁸ Texas Health and Human Services Commission. (July 2, 2010). *Health and Human Services System Strategic Plan 2011-15*, p. 145. Retrieved from: http://www.hhs.state.tx.us/StrategicPlans/SP11-15/Strategic_Plan.pdf

²⁹ Ball, A. (January 26, 2012). *Judge: Mentally incompetent state inmates being kept in jail too long*. Retrieved from the Austin-American Statesman website: <http://www.statesman.com/news/news/local/judge-mentally-incompetent-state-inmates-being-kep/nRjz7/>

³⁰ Department of State Health Services, Continuity of Care Task Force. (July 2012). *Final Report*, p. 1. Retrieved from: <http://www.dshs.state.tx.us/mhsa/continuityofcare/>

³¹ Texas Health and Human Services Commission. (July 2, 2010). *Health and Human Services System Strategic Plan 2011-15*, p. 147. Retrieved from: http://www.hhs.state.tx.us/StrategicPlans/SP11-15/Strategic_Plan.pdf

³² Ibid, p. 146

³³ Padilla, G. (2011, October 28) *Training helps officers deal with mentally ill: Treatment, not jail, often is seen as best solution*. Retrieved from MySanAntonio.com website: <http://www.mysanantonio.com/news/article/Treatment-for-mentally-ill-better-than-jail-2241568.php>

³⁴ Ibid

³⁵ Ibid