Health and Human Services

Statewide Interagency Aging Services Coordinating Council

March 4, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.

Statewide Interagency Aging Services Coordinating Council ensures a strategic statewide interagency approach to aging services. Core duties of the SIASCC include:

- Developing and monitoring the implementation of a recurring five-year statewide interagency aging services strategic plan.
- Developing biennial coordinated statewide interagency aging services expenditure proposal.
- Annually publishing an updated inventory of state-funded aging programs and services.

Voting Members

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Aging Texas Well Coordinator, Office of Aging Services Coordination
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Budget and Policy Advisor, Office of Budget and Policy
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Ex Officio Members

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Dr. Elena Volpi
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and Aging Studies
The University of Texas Health Science
Center at San Antonio

Council Resources

- 2025-2030 Texas Statewide Interagency Aging Services Strategic Plan (PDF)
- 2025 SIASCC Inventory of State-Funded Aging Services and Programs (PDF)
- 2024 SIASCC Inventory of State-Funded Aging Services and Programs (PDF)
- FY 2024 SIASCC Coordinated Expenditure Proposal (PDF)
- Read SIASCC reports.

1. Welcome, opening remarks, new member introductions and roll call.

The meeting was convened by Chelsea Couch. New member was welcomed: Austin Kinghorn, Deputy Attorney General for Civil Litigation (Office of the Attorney General).

2. Consideration of December 10, 2025, draft meeting minutes.

The minutes were approved as drafted.

3. Consideration of council bylaws.

The advisory committee common by-laws were discussed. The Council reviewed first iteration of SIASC bylaws, aligned with other HHSC advisory bodies and Texas Government Code 526.0801–.0809 (Subchapter 2). Bylaws highlights covered:

- council purpose/charges (recurring 5-year strategic plan; biennial coordinated expenditure proposal due Nov 1 of even-numbered years; annual inventory of state-funded interagency aging services/programs).
- Membership structure and terms: voting members serve six-year terms; ex officio members may serve beyond six years.
- Officer structure: presiding officer role established by statute (Office of Aging Services Coordination); bylaws add a vice chair to ensure continuity when the presiding officer is unavailable.

Next meeting will include nomination and election of a vice chair. Post-adoption, members will receive a statement to sign acknowledging receipt of adopted bylaws and agreement to adhere to them.

Motion to adopt bylaws prevailed

4. Special topic presentation – Mental Health in Older Adults. Natalie Maples, DrPH, MA Stacey Stevens Manser, PhD, UT San Antonio

Summary. Texas is aging rapidly; 65+ is the fastest growing age group with projected 88% increase (2023–2050), with rural areas facing fewer behavioral health services. Population indicators were discussed (65+ / 60+ references):

- Texas exceeds U.S. on frequent mental distress and avoided care due to cost;
- suicide and drug death rates discussed;
- social isolation reported as elevated (noted figures for females and males age 60+).

Behavioral health often shows up as functional impacts in other systems: falls, repeated 911/ED use, avoidable rehospitalizations, missed appointments, medication mismanagement, sleep disruption/pain, agitation, isolation/bereavement, increasing substance use (including medication interactions), and caregiver strain.

Drivers and "lookalikes" can delay detection: depression as apathy/withdrawal, anxiety as agitation/somatic complaints, substance use as falls/confusion/med interactions. Planning implications were emphasized. Improving outcomes doesn't require every agency to deliver therapy, but does require cross-system supports (screening, warm handoffs, transportation, benefits navigation, caregiver supports, safety planning, and follow-up after transitions).

Serious Mental Illness (SMI) (e.g., schizophrenia, schizoaffective disorder, bipolar disorder, severe major depression) is linked to recurring exacerbations/hospitalizations, earlier aging threshold (often 50+), higher medical burden, and a mortality gap that is estimated to be 10–25 years.

Evidence-based strategies include: collaborative care, primary-care based depression models (e.g., PROSPECT), SBIRT screening for risky alcohol/medication misuse, trauma-informed approaches, caregiver support/social connection interventions.

Cognitive Adaptation Training (CAT) was discussed in detail. Environmental supports (signs, calendars, checklists, routines) can help to bypass cognitive barriers (not cure them). These are tailored/person-centered and are often delivered via repeated visits. These services are billable under psychosocial rehabilitation in Medicaid.

Case example (Mr. Jones, 63, schizophrenia) was presented

Money Follows the Person (MFP) Behavioral Health Pilot (2012–2017 was described and evaluation data 2008–2017 was presented:

- invited eligible individuals with SMI in nursing facility level of care;
- 6 months pre-transition support and 1 year follow-up;
- 492 enrolled and 450 transitioned (Austin/San Antonio), with partnerships across MCOs, providers, researchers, STAR+PLUS, local mental health authorities, and others.

Outcomes were shared: 70% completed a year in the community; over 65% remained in the community (some over 8 years); reported sustained improvements in functioning/quality of life and increased independence.

Cost findings: HCBS costs compared to nursing facility costs; recoup time cited (5.3 months dual eligible; 4.5 months Medicaid-only) and net Medicaid savings of $24.5M. There are current pilots in progress: “Bridge to STAR+PLUS” (state hospital to community with CAT-trained transition specialist and peer specialist) and an MCO transition pilot (Travis and Bexar SDAs) focused on nursing facility transitions. Early results show improvements on certain domains and recovery/well-being measures, plus improved satisfaction with housing.

The International Center of Excellence for Evidence-Based Practices (icebep.com) offers training/TA and resources (CAT, CBT for psychosis, Mental Health First Aid, motivational interviewing, suicide risk assessment, trauma-informed care), including a 20-minute Aging and Behavioral Health e-learning module and financial wellness services.

Presentation

Texas is Aging Fast Texans age 65+ are the fastest growing age group.

- 88% Projected to increase in Texans age 65+ (2023-2050).
- In 76 of 254 counties, adults 65+ already outnumber children –predominantly rural counties with fewer local services.

This demographic shift will affect nearly every system: health care and behavioral health, housing, transportation, emergency response, and long-term services and supports.

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Behavioral Health Belongs in Aging Services

Selected indicators – Texas vs U.S.

Indicator (age 65+)	Texas	U.S.
Frequent Mental Distress	9.8%	8.7%
Suicide Deaths (per 100,000)	17.5	17.7
Drug Deaths (per 100,000)	10.2	13.3
Avoided Care due to Cost	7.4%	3.6%
Felt Socially Isolated (age 60+) Female Male	 30% 23.4%	 27% 22.2%

Behavioral Health Shows Up as Functional Impact

- Falls, repeat 911/ED use, and avoidable re-hospitalizations.
- Missed appointments and medication mismanagement (polypharmacy + confusion).
- Sleep disruption, pain, and agitation that look "medical" first.
- Isolation/bereavement → withdrawal, low motivation, reduced self-care.
- Substance misuse hidden in falls, confusion, or medication interactions.
- Caregiver strain/burnout → crisis-driven care decisions.

Behavioral Health in Older Adulthood Behavioral health in later life is shaped by the interaction of medical complexity, functional change, life transitions, and social context. Common drivers are: isolation/bereavement, chronic pain and sleep disruption, sensory loss, cognitive change, role transitions (retirement/caregiving), cumulative trauma.

High-risk windows: recent hospitalization, new disability, medication changes (esp. sedatives/opioids), housing instability, caregiver burnout.

"Look-alikes" that delay detection:

- Depression can present as apathy/withdrawal
- Anxiety can look like agitation/somatic complaints
- Substance misuse can be hidden in falls/confusion/med interactions.

Planning Implications for Agencies As the 65+ population grows, the absolute number of Texans experiencing depression, anxiety, trauma reactions, substance

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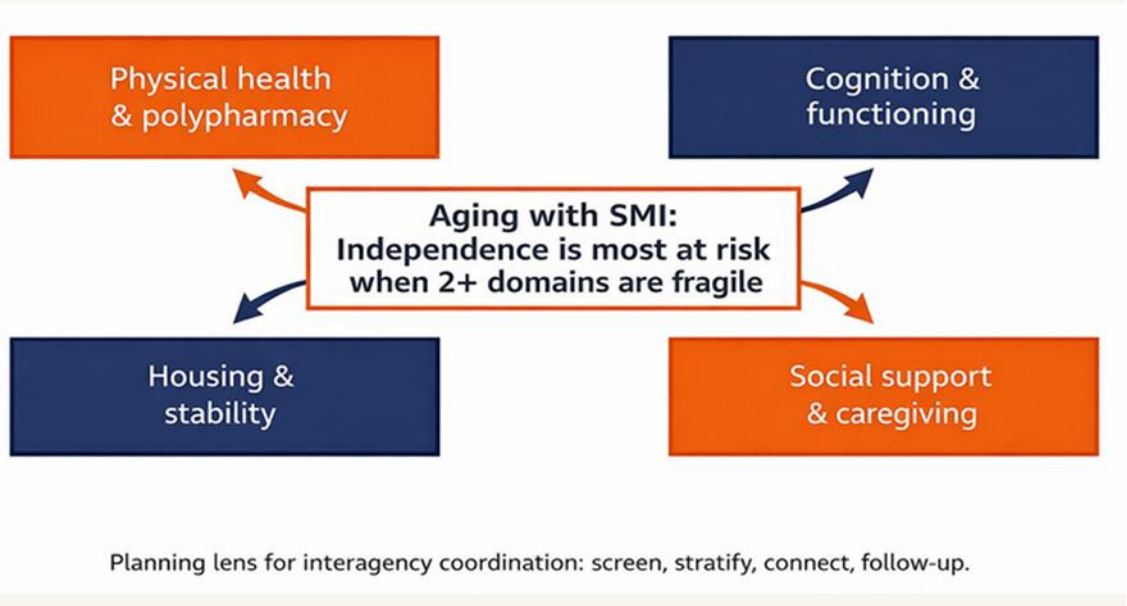
misuse, suicide risk, and mental illness will rise – even if rates stay the same. Cross-system "safety signals" (e.g., falls and elder abuse) can also be behavioral health signals:

- 1 in 4 older adults report a fall each year.
- About 1 in 6 adults age 60+ experience some form of abuse. Improving outcomes doesn't require every agency to deliver therapy**.**

It requires coordinated, practical supports: screening, warm handoffs, transportation, benefits navigation, caregiver supports, safety planning, and follow-up after transitions.

Aging with Mental Illness: Interagency Coordination



Planning lens for interagency coordination: screen, stratify, connect, follow-up.

Serious Mental Illness (SMI): Is a group of mental health conditions that result in serious functional impairment and interfere with major life activities and includes schizophrenia spectrum disorders, bipolar disorder, and severe major depression. SMI is characterized by recurring exacerbations and multiple hospitalizations.

- One of the leading causes of disability worldwide.
- People living with SMI often age with higher medical burden, higher risk of social isolation, and greater vulnerability during system transitions.

Serious Mental Illness (SMI): Aging Population

- Earlier "aging threshold": many systems use age 50+ when planning supports for people with SMI because medical comorbidity and functional decline often occur earlier.

- High medical risk: people with SMI experience markedly elevated rates of cardiovascular disease, diabetes/metabolic conditions, and smoking-related illness.
- The mortality gap is commonly estimated at 10–25 years earlier than the general population.
- High system-contact risk: hospitalizations, crisis episodes, and housing disruptions can accelerate loss of independence without coordinated follow-up.

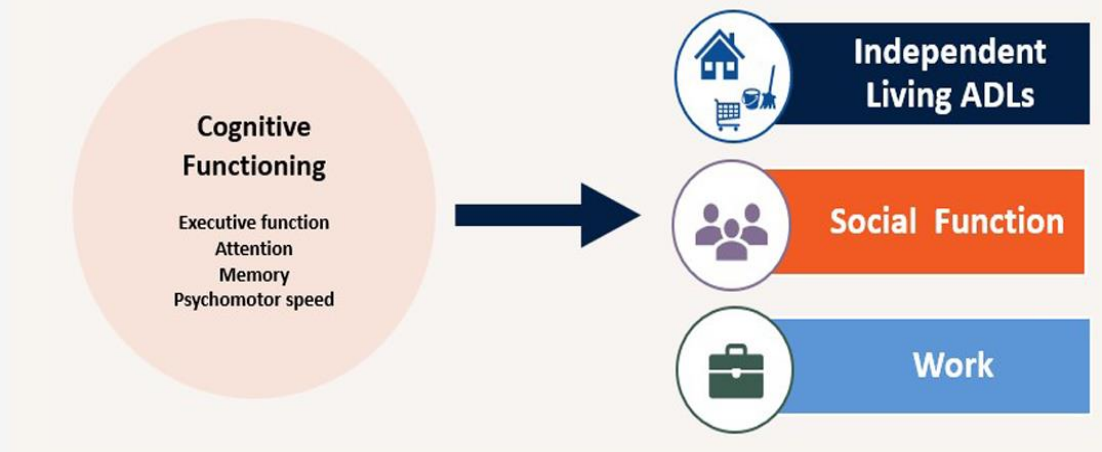
Serious Mental Illness (SMI): Symptoms

- Psychosis – Delusions, hallucinations, disorganized speech or behavior
- Behavioral Challenges – Amotivation, decreased activity, social withdrawal, substance use, insomnia
- Mood and emotional – Depression, mania, anxiety
- Cognitive – Attention, memory, executive functions, psychomotor speed

Serious Mental Illness (SMI): Executive Functions

- Planning – Formulating plans for goal directed behavior
- Organizing – Sequencing behavior and thought
- Focusing – Maintain goal-directed-action in the face of distraction
- Gate Keeping – Inhibit irrelevant or inappropriate behavior

Cognitive Functioning Predicts Real-World Outcomes



Evidence-Based Strategies

Strategies that Translate to Aging Systems

- Collaborative care in primary care (e.g., IMPACT) improves depression outcomes and functioning for older adults when paired with care management and psychiatric consultation
- Primary-care-based depression care models (e.g., PROSPECT) can reduce suicidal ideation and depression in older adults by improving detection and treatment follow-through
- SBIRT and older-adult tailored SUD approaches help identify risky alcohol and medication misuse early, before falls, delirium, and hospitalization
- Trauma-informed approaches, caregiver supports, and social connection interventions can reduce isolation and improve engagement
- Cognitive Adaptation Training

Cognitive Adaptation Training (CAT) is a psychosocial intervention using environmental supports like signs, calendars, and checklists are used to help people bypass difficulties in cognitive functions and improve success in everyday behaviors. It is designed using principles from the field of occupational therapy. CAT interventions help overcome challenges in thinking and motivation, which are often barriers to recovery, independence, and functioning.

Environmental supports in CAT are tailored to help individuals:

- develop healthy habits
- change behaviors by reducing task complexity
- encouraging consistent behavior patterns
- ensuring that all necessary tools are readily accessible.

By organizing personal belongings and establishing structured routines, CAT facilitates the successful completion of essential activities of daily living. CAT is rooted in a person-centered approach to care – collaborate to identify goals the individual finds meaningful and together they create individualized strategies for reaching those goals.

In addition, CAT:

- Is completed in the individual's home environment.
- Is evidence-based (20+) years), including MFP-BHP 10 years.
- Is a manualized treatment.
- Uses a motivational strengths perspective to facilitate personal initiative and independence for the goal of improved health. MI optimizes peoples' psychological commitment.
- Is billable under psychosocial rehabilitation.

CAT: Common Areas of Intervention:

- Bathing
- Care of Living Quarters
- Dental Hygiene
- Dressing
- Grocery Shopping
- Leisure/Social
- Money Management
- Orientation
- Toileting
- Transportation
- Work and Vocational

Characteristic Behaviors

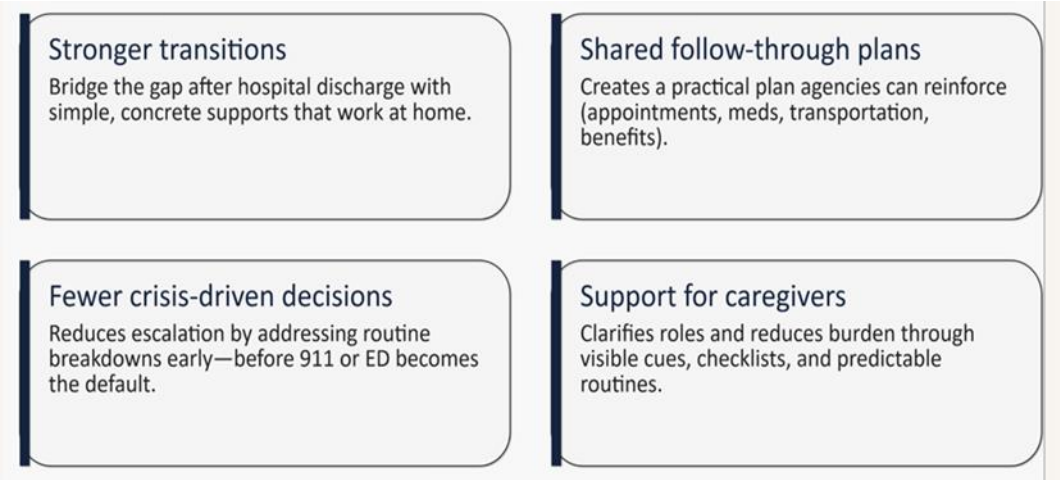
Apathy	Disinhibition	Mixed
Difficulty initiating tasks. Struggle to begin necessary activities without prompts. May not complete tasks – too overwhelming.	Difficulty staying organized and on task. Easily distracted, behave impulsively, or act in ways others may deem inappropriate. Reactive to their environment.	Includes characteristics of both apathy and disinhibition. Individuals may have trouble initiating tasks and may become distracted while performing tasks.

Characteristic Behaviors – Suggested Strategies

Apathy	Disinhibition	Mixed
Prompt initiating tasks. Break tasks down into smaller steps. Provide support for sticking with and completing tasks.	Remove unneeded items, reduce clutter. Use alerting tones or signs to redirect the individual when they get off track. Establish a consistent daily routine.	Use disinhibition strategies to remove cues for behaviors getting in the way of goals. Use apathy strategies to prompt initiation of intended behaviors.

A case study was presented but not described here

What CAT Enables for Interagency Coordination



MFP Behavioral Health Pilot

2012-2017: Intervention

- Transitioned adults with mental illness from nursing facilities to communities.
- Six months of pre-transition care and one year in the community.
- Partnered with managed care organizations (MCOs), providers, researchers, STAR+PLUS members, local mental health authorities (LMHAs), and others.
- Tested positive changes to Medicaid system.

MFP Behavioral Health Pilot: **Structure**

Behavioral Health Pilot Services

- Cognitive Adaptation Training (CAT)
- Substance use counseling
- Employment assistance
- Housing location assistance

Managed Care

- Assessment and referral
- Service Coordination
- Health and LTSS
- Relocation assistance
- Weekly meetings (Pilot team, MCOs)

MFP Behavioral Health Pilot: Outcomes

- 450+ transitioned to the community.
- 70% completed a year in the community.
- Over 65% remained in the community, some for over eight years (2016 Evaluation).
- People experienced and sustained improved functioning and quality of life.
- Examples of increased independence included getting a paid job, driving, getting a high school or college education, teaching art, leading peer support groups.

MFP Behavioral Health Pilot: Cost Benefit

- Texas HCBS costs are 60% of nursing facility costs for Medicaid-only clients and 42% for dual (Medicare/Medicaid) eligibles.
- For dual eligibles, it took 5.3 months to recoup program costs. For Medicaid only clients, it took 4.5 months.
- Net Medicaid savings were $24.5 million.
- Integrating behavioral health services into long term services is a good investment from a human and economic perspective.

Source: Updated MFP BHP Medicaid Cost Analysis, UT Addiction Research Institute, Austin, Texas, 2016

Additional Pilots – Similar Structure

Bridge to STAR+PLUS and MCO Transition Specialist

- Transition adults with mental illness from institutional care (state hospitals and nursing facilities) to the community.
- Intensive Transition Services including coordinating pilot services and other resources that support successful transition into the community.
- Continue to disseminate MFP best practices to MCOs and providers.
- Develop and implement strategies to ensure that best practices for relocating people with SMI from institutions are embedded and sustained in the Texas Medicaid system

Center of Excellence: Evidence-Based Practices

Advancing evidence-based behavioral health care through training, implementation support, applied research, and resource development.

Strengthen workforce capacity to promote stability, reduce avoidable crisis service use, and support people in

- Cognitive Adaptation Training
- Cognitive Behavioral Therapy for Psychosis
- Mental Health First Aid
- Motivational Interviewing
- Reflective Training
- Suicide Risk Assessment and Safety Planning
- Trauma Informed Car

achieving meaningful, self-directed lives
in the community.

Evidence-Based Practices | ICE-EBP
Sustaining Independence | ICE-EBP
Behavioral Health Awareness

Discussion

Clinical community linkages are found in models that are "out there" and can be found in research. There are models of acre and getting the word out is the issue.

- Community-Clinical Linkages with Community Health Workers in the United States: A Scoping Review - PMC
- astho-strengthening-community-clinical-linkages.pdf
- IJFRBPS-2025-0022.pdf
- Lohr-HPP-CHWs-in-CCL-lit-rev.pdf

Using interagency coordination to track studies identifying frequent users and other issues. The speaker stated collaboration with managed care has been their greatest success. Collaboration has been going on for more than a decade. MCOs are initiating wrap around services and they are employing CAT. The data collected has been qualitative we hope to be collecting more data by reaching out to other agencies. Training for caregivers is also happening. A real level of partnership and understanding is a key part of this.

Financial wellness has been a way that we supported caregivers. Money Management for Older Adults; financial-well-being-older-americans_report.pdf

5. SIASCC member updates relevant to council focus.

- Office of Aging Services Coordination updates: Aging Texas Well Strategic Plan kickoff webinar held Jan 21 with 160+ cross-sector partners; four workgroups launched for 2026–2029 domains (access to services, healthy aging, caregiver support, age-friendly). HHSC Aging Texas Well: A Multisector Plan on Aging Stakeholder Kickoff
- Disaster preparedness training update: ARPA funding of $250,000 (expended by Aug 31) to develop training for aging services providers, healthcare workers, emergency personnel/first responders, volunteers, and community members

supporting older adults and caregivers during disasters; work underway including seeking CEUs.

- SIASC coordinated expenditure proposal: next iteration due Nov 1; members thanked for Phase 1 submissions (confirm FY24 expenditures; provide FY25 actuals); reminders for remaining submissions and extensions were noted.
- UT Austin: "Livability for Longevity Symposium" at LBJ School, April 13, 9 AM–1 PM; free registration and lunch; link to be emailed to Chelsea Couch for distribution.
- Texas Workforce Commission (Older Individuals Who Are Blind program): expanded into three units; hiring with 11 new FTEs; additional funding for "Senior Keys to Independence" (4-day group skills training) with current sites (San Antonio, Dallas Lighthouse, Austin Lighthouse); open enrollment for additional entities; upcoming open enrollment for contracted providers (Orientation & Mobility, Independent Living Skills, Assistive Technology trainers, diabetes educators).
- DSHS: launched Dementia Care Project ECHO with Texas Tech HSC (6-session virtual series Jan 28–Apr 8 with CE credits); They participated in TARCC symposium Jan 22; dementia support grants have 10 recipients serving 48 counties providing referral, caregiver connections, community/clinical partnerships, workforce development.
- UNT HSC Center for Older Adults partnered with James L. West Center for Dementia Care to launch an online dementia specialist certification program with free continuing education Specialist in Aging Certificate | University of North Texas
- Texas Council for Developmental Disabilities described their article on aging with developmental disabilities and inclusion programming (with Texas A&M AgriLife Extension) published in Journal of Human Sciences and Extension.
- UT Health San Antonio Barshop Institute: awarded ARPA-H contract up to $38M for a health span-extending interventions clinical trial in South Texas with multiple partners; recruiting expected early next year.

6. Public comment. No public comment was offered

7. Action items and agenda items for next meeting.

Action and Agenda Items--No items

Upcoming Meetings:

- June 10, 2026 (9 a.m.)
- September2, 2026 (9 a.m.)
- December 2, 2026 (9 a.m.)

8. Adjourn. There being no further business, the meeting was adjourned.
