



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Texas**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

As per the Title V Block Grant Guidance dated July 15, 2005, the appropriate assurances and certifications are being maintained in the Title V Director's office and are available upon request. Please call Fouad Berrahou and/or Shirley Broussard at 512-458-7321 if you have questions or need to view the assurances and certifications.

//2008/ Please contact Fouad Berrahou and/or Sam Cooper at 512-458-7321 if you have questions or need to view the assurances and certifications.//2008//

//2009/ Please contact Fouad Berrahou at 512-458-7111, extension 3207, and/or Sam Cooper at extension 2184 if you have any questions or need to review the assurances and certifications. //2009//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Public input on issues surrounding MCH/CSHCN continues to be an important component of the Title V program and its operations. Despite the abolishment of most Title V advisory committees by the 78th Legislature in 2003, Title V program areas have routinely used several mechanisms for soliciting public input. Different Title V programs regularly convene informal advisory committees, workgroups, focus groups, or other bodies to address diverse health issues, such as health disparities, integration of primary health care with mental health, and medical home. Several Title V program areas also have well-populated email distribution lists that are actively used to share information and solicit feedback relative to policy changes. In addition, most email distribution lists include advocacy groups and parents interested in Title V. Currently, several roundtables are organized across Texas with women's health providers to provide program updates and discuss impact of mandates from the recently completed 79th Legislature.

The Title V application development was made available to facilitate comment throughout the 5-year needs assessment, which reflect comprehensive knowledge gained through interactions with Title V stakeholders. After its transmittal, the application will be posted on the Title V website and a notice of its availability, electronically or in hard copy, will be sent to those stakeholders who participated in the 5-year needs assessment.

//2007/ Title V grant applications are made available to the public on the DSHS MCH webpage. Hard copies are also available to Title V stakeholders upon request. //2007//

/2008/ Title V grant applications are made available to the public on the DSHS MCH webpage. Web links are updated to provide access to the most current application and the latest 5-Year Needs Assessment. Hard copies are also available to Title V stakeholders upon request. //2008//

/2009/ The Title V Grant Application for FY08 was made available to the public on the DSHS MCH website in the fall of 2007. The last Title V 5-Year Needs Assessment is included as well. In June 2008, a draft of the FY07 and FY08 activity reports and the FY09 activity plans associated with the national and state performance measures was posted for review and comment. Title V-funded contractors and other stakeholders were notified of the posting. After the Block Grant Review, the FY09 Application and FY07 Annual Report will be finalized and posted on the DSHS MCH website for public access. In FY09, additional efforts to seek public comment are planned through contractor conference calls and updated website options.//2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The following priority needs were identified in the FY06 Five Year Needs Assessment and in the block grant applications of 2006 and 2007 and remain the focus of the DSHS Title V Program for 2008:

1. Increase partnerships with families of CSHCN in decision-making at all levels and family satisfaction with the services they receive.
2. Increase the number of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.
3. Reduction of institutionalized CSHCN.
4. Decrease adult obesity.
5. Improve and expand healthcare infrastructure.
6. Decrease the number of women of childbearing age who smoke.
7. Decrease childhood obesity.
8. Increase access to dental care.
9. Reduce domestic violence.
10. Increase the number of youth with special health care needs who receive the services necessary to make transition to all aspects of adult life.

Additional priority need as noted in Form 14: Improve the organization and coordination of community-based service systems for CSHCN and their families so that an increased number of families of CSHCN report that these systems are easy to use.

The process for creating the list is described in the Five Year Needs Assessment and included collection and analysis of qualitative and quantitative data. Stakeholders, including clients, families, providers, and other health and human service agency staff were invited to participate in the identification and prioritization of the needs for the state. DSHS staff continue to collaborate with partners serving women and children, including children and youth with special health care needs, to monitor and assess the status of these priority areas. This information will be incorporated into future applications and the next Five-Year Needs Assessment.

//2009/ As a result of these ongoing efforts, changes to the priorities listed in Form 14 for FY09 include the replacement of number 3 above with the following: "Increase recruitment and retention of CSHCN Services Program providers." The priority of decreasing the number CSHCN in institutions remains and is included in the form notes as an additional need. //2009//

Throughout the fiscal year 2007, agency staff performed a variety of assessments related to the maternal and child health populations. The following brief descriptions are provided with the associated performance measure or health indicator.

WIC / Breastfeeding Survey - Annually, WIC surveys clients to measure attitudes, practices, beliefs, and knowledge pertaining to breastfeeding to gain further insight into barriers to breastfeeding in order to improve programmatic initiatives. In 2005, over 6,000 surveys were completed among the 76 WIC clinics. The most recent report can be found at <http://www.dshs.state.tx.us/wichd/nut/neplan.shtm>.

//2009/ The FY07 Findings from the 2007 WIC Infant Feeding Practices Survey are available at the following link:

<http://www.dshs.state.tx.us/wichd/nut/pdf/InfantFeedingPracticesSurvey.pdf>
Questions about this report or requests for copies of the survey instrument should be directed to either Tracy Erickson Tracy.Erickson@dshs.state.tx.us in the Nutrition Services Section or Brian Castrucci (Brian.Castrucci@dshs.state.tx.us the Office of Title V, both of the Division of Family and Community Health Services. //2009//(NPM 11)

Family Planning (FP) Survey - In response to the recent implementation of the Texas Medicaid Waiver for FP services to eligible women up to 185% of poverty, DSHS staff designed and implemented a survey to measure provider attitudes toward and barriers created by this expansion of services. The survey was distributed to over 150 contractors and solicited suggested policy changes that would improve service delivery to Title V, X and XX clients after the waiver implementation. The analysis of responses will be complete in July 2007.
//2009/ The survey was completed and results were used to guide policies regarding Family Planning. //2009//
(NPM 8)

March of Dimes Survey - As part of their efforts to address high rates of prematurity and infant mortality, the Texas Chapter of the March of Dimes implemented a pilot program to deliver positive health messages through faith-based setting for African American pregnant women.
//2009/ Positive results from the pilot led to expanded efforts in Houston, Dallas, Ft Worth, and San Antonio in FY07. Title V staff continue to assist with evaluation.//2009// (Health System Capacity Indicator 5 A&B)

PRAMS Analysis - Annually, 3,600 women are surveyed on their experiences before, during, and after pregnancy as part of Texas' Pregnancy Risk Assessment and Monitoring System (PRAMS). PRAMS data, which are available for 2002 through 2004, have been analyzed for inclusion in presentations to community stakeholders and published in the annual data book. **//2009/**
<http://www.dshs.state.tx.us/mch/pdf/PRAMS%20annual%2004%20FINAL.pdf>**//2009//**(NPM 15 & 18)

//2009/ Needs assessment activities in FY08 have included ongoing contact and discussions with Title V-funded contractors that provide services to CSHCN and MCH populations. Conference calls with contractors and regional DSHS staff are used to obtain information regarding challenges and best practices in several of the programs operating in the Family and Community Health Services Division.

Following the block grant review in August 2007, Title V staff initiated an intra-agency workgroup to assess the resources and activities focused on injury and violence prevention in MCH. As a result of the initial efforts and common belief in the potential partnerships across the agency, Assistant Commissioners from Family and Community Health Services, Mental Health and Substance Abuse, and the Prevention and Preparedness Divisions jointly requested assistance from the State & Territorial Injury Prevention Directors Association. A State Technical Assistance Team visit was approved for September 2008 and preparations are underway.

Following the success of the East Texas Needs Assessment in FY07, DSHS initiated an assessment of community health needs in 12 West Texas counties in March 2008. The purpose of regional community health assessment was to identify barriers to health care within the selected counties, in order to implement effective health disparities projects among the assessed counties. The process has included gathering information at public forums and through surveys in English and Spanish. Responses are being sought from those who live and/or work in the target area. The assessment report is scheduled to be available in the fall of 2008. //2009//

III. State Overview

A. Overview

The Department of State Health Services (DSHS), which administers the Title V program, operates within a structure defined by 11 Health Service Regions (HSRs) for the provision of essential public health services to all Texans. A map is attached (Attachment A) to serve as a reference throughout the application.

The purpose of the Texas Title V Program is to address the overall intent of the Maternal and Child Health (MCH) Services Block Grant to improve the health of all mothers, women of childbearing age, infants, children, adolescents and children with special health care needs (CSHCN). The state of Texas has responsibility to provide and assure access to quality MCH services for mothers and children; provide and promote family-centered, community-based, coordinated systems of care for CSHCN and their families; and facilitate the development of community-based systems of care for the MCH and CSHCN populations.

Texas' Title V Program operates within the strategic plan framework articulated by Texas State Government; the Texas Health and Human Services Commission (HHSC), the state agency responsible for leading and overseeing the health and human services agencies and ensuring that they function as a system; and the Texas Department of State Health Services (DSHS), the state agency responsible for administration of the Title V program. DSHS was newly established and began operations on September 1, 2004, as a result of the passage of House Bill 2292 during the 78th Legislative Regular Session in 2003. HB 2292 established a clear directive to transform the delivery of health and human services in Texas. The consolidation of 12 agencies into a network of four new departments under the leadership of HHSC was designed to improve services, increase efficiency and enhance accountability among the state's health and human service agencies. This act consolidated the programs of the Texas Commission on Alcohol and Drug Abuse, the Texas Department of Health, the mental health components of the Texas MHMR, and the Texas Health Care Information Council into a single department called DSHS. This consolidation has presented opportunities to integrate primary health care with behavioral health care effectively and to make health information more accessible.

DSHS administers both the MCH and CSHCN programs within the Division of Family and Community Health Services (FCHS). The CSHCN Services Program (CSHCN SP), Kidney Health Care Program, Hemophilia Assistance Program, and Anatomical Gift Education Program have been consolidated into the Purchased Health Services Unit within FCHS. In addition, this consolidation effort provided an opportunity to situate subject matter experts of women's health, child health, adolescent health, perinatal health systems, the Block Grant Administrator, as well as the Texas Primary Care Office staff under the oversight of the State Title V Director.

Integration efforts are expected to continue well into FY 2006. As stated earlier, DSHS includes programs from the former Texas Department of Health as well as the state mental health and substance abuse service programs. Both MCH and CSHCN programs are already exploring opportunities for enhanced service coordination with children's mental health services staff.

/2007/ DSHS' reorganization over the past 2 years has led to increased collaboration between experts in physical and mental health. An example of this collaboration brought subject matter experts on perinatal health together with DSHS mental health services staff to form the Substance Abuse and Birth Outcomes Working Group. The mission of this working group is to assess the impact of substance abuse on birth outcomes using treatment data, Medicaid claims data, vital records data, and WIC data. Another collaboration brought CSHCN staff together with DSHS mental health services staff to provide substantive input into a request for proposals issued by the Department of Family and Protective Services to revamp the foster care system in Texas.//2007//

/2008/In the fall of 2006, the HHSC completed an organizational assessment of DSHS in efforts to improve the performance of the agency. The assessment focused on the organizational structure and decision making at the executive management level, business support functions, behavioral health services and the DSHS Agency Council. Agency leadership began implementing recommendations under the leadership of Dr. David Lakey as the new Commissioner. In addition, roles of DSHS executive staff were clarified and aligned with those of the Health and Human Services enterprise agencies.//2008//

/2009/ Deputy Commissioner Southern continues to lead efforts to integrate physical and behavioral health through the development of a Comprehensive Integration Plan in FY08. Ongoing projects include Mental Health Transformation, Crisis Services Redesign, Integrated pediatric and Mental Health, and FQHC Incubator Support of Mental Health Services.//2009//

/2008/ CSHCN SP staff provided input into the DSHS and HHSC strategic planning processes and continue to attend meetings to identify, support, and enhance, if feasible, agency and stakeholder activities that promote progress toward the Title V CSHCN performance measures. CSHCN SP staff and the statewide Medical Home Workgroup participate in implementing strategic plan activities for the Access to Insurance and Medical Home component of the Texas Early Childhood Comprehensive Systems (TECCS) initiative (Raising Texas). CSHCN SP staff have expanded training and technical assistance to the program's service contractors and DSHS Regional Managers of Case Management and Social Work Services through quarterly conference calls. Contractor proposals and quarterly reports include activities specific to the Title V CSHCN performance measures. //2008//

/2009/ CSHCN SP staff continue to serve as active participants and leaders for the Access to Insurance and Medical Home component of the Texas Early Childhood Comprehensive Systems (TECCS) initiative (Raising Texas). //2009//

The Title V program is an important component in achieving the Visions, Missions, Philosophies, and Benchmarks for Texas' priority goal for health and human services. As outlined by the Governor's Office of Budget, Planning and Policy, this primary goal is to reduce dependence on public assistance through an efficient and effective system that promotes the health, responsibility, and self-sufficiency of individuals and families. The statewide benchmarks relevant to this goal are consistent with requirements of Title V program and Title V national outcome and performance measures. The relevant statewide benchmarks include: infant mortality rate; low birth weight rate; teen pregnancy rate; percent of births that are out-of-wedlock; incidence of vaccine-preventable diseases; rate of substance abuse and alcoholism among Texans, and number of surveillance activities and field investigations conducted for communicable disease injury or harmful exposure. The vision, mission, and driving principles of DSHS further support and strengthen the Texas Title V program.

DSHS vision statement: Texans have access to effectively delivered public health, medical care, mental health and substance abuse services and all Texans live and work in safe, healthy communities.

DSHS mission statement: The Department of State Health Services promotes optimal health for individuals and communities while providing effective health, mental health and substance abuse services to Texans.

We accomplish our mission by providing and supporting:

1. Essential public health services of:

- Surveillance, diagnosis and investigation of diseases, health problems and threats to the public's health.
- Education, empowerment and mobilization of individuals and communities to prevent health problems and improve their health status.

- Promotion of health policies and planning for individuals and community efforts to improve their health.
- Regulation and enforcement of public health laws and policies necessary to control disease and protect the public's well being.
- Facilitating access to health services for individuals of greatest need.
- Critically evaluating and refining our public health activities and workforce competence.
- Supporting the health care safety net for children and adults with special health care needs, uninsured and underinsured people and families.

2. DSHS driving principles and values of: Sound Mind-Sound Body; Prevention First Approach; and Partnerships to improve access to and availability of care, reduce health disparities, and eliminate the stigma of mental illness, and to build a successful public health system.

/2009/ In November 2007, Dr. Lakey shared his observations and assessment of DSHS during his first year in the position as Commissioner. Working with agency leadership, he developed a new vision and mission statement with strategic goals that are included below.

Vision: A Healthy Texas

Mission: To improve health and well-being in Texas

Goals/Objectives:

Prevent and prepare for health threats

Build capacity for improving community health

Promote recovery for persons with infectious disease and mental illness

Protect consumers

Develop and expand integrated services

Streamline administrative systems

Maintain and enhance DSHS assets and technology

Nurture a unified workplace culture

Expand the effective use of health information

Build and sustain effective partnerships//2009//

At the core of DSHS' strategic plan are priority needs established in partnership with external and internal stakeholders and consumers, the former Board of Health, and DSHS executive managers. Through these priority needs, DSHS works toward strengthening the health status of individuals and enhancing public health systems in Texas. These six priorities focus on achieving a healthy Texas and are consistent with Title V program:

1. Improving Immunization Rates. Results of the 2003 National Immunization Survey (NIS) show that 78.1% of Texas children ages 19 months through 35 months were fully vaccinated in the 4:3:1 vaccine series, the highest level Texas has ever achieved. This figure represents a 9.5% increase (6.8 percentage points) over the previous year's 71.3%. While this an improvement from the previous year, Texas' vaccine coverage level has been lower that the national level since 1996. DSHS has the challenge of raising immunization levels through a collaborative effort that demands local involvement and the commitment of other state programs and agencies. This effort also requires the commitment of parents, businesses, and schools. To this end, DSHS has directed many of its efforts to build community coalitions, educate medical providers about the importance of immunizations, implement the Texas' Immunization Registry ImmTrac, and raise public awareness through a \$1.5 million advertising campaign to encourage parents to get their children two years old and younger vaccinated on an age-appropriate schedule. The campaign includes billboards, radio, television and print ads in English and Spanish and focuses on selected areas with low immunization rates.

/2007/ DSHS is planning to request legislative appropriations to purchase meningococcal vaccine and Human Papilloma Virus (HPV) vaccine to immunize children in need who are underinsured

and present for services at any clinic site enrolled in the TVFC. //2007//

/2008/Effective 2/1/07, providers and clinics enrolled in the TVFC Program were notified that both the HPV and meningococcal vaccines were available for use.//2008//

2. Promoting Healthy Eating and Regular Physical Activity. Overweight and obesity are associated with increased risks for several diseases including heart diseases and diabetes. Over one-third of adults in Texas were overweight in 2004. The prevalence of overweight children is far worse in Texas than in the nation as a whole. Further illustrating the priority of this issue in Texas, in 2002, Governor Rick Perry appointed an 11-member Advisory Committee on Physical Fitness to provide advice on issues relevant to physical fitness. The DSHS Commissioner was appointed to this advisory committee. At DSHS, several efforts are underway to educate individuals and communities about the benefits of physical activity and good nutrition. An example of these efforts is the Building Healthy Families Initiative. In cooperation with Blue Cross and Blue Shield of Texas, the Caring for Children Foundation of Texas, HEB grocery stores, Texas Medical Association, Texas Hospital Association, and the American Heart Association of Texas, DSHS launched this new initiative on September 5, 2004 for a fall tour of major Texas cities. The two-part purpose of Building Healthy Families is to raise awareness of the long-term health risks associated with obesity in adults and children, and to inspire small lifestyle changes that can lead Texans to live healthier lives through exercise and better food choices. This Initiative was based on the 2003 DSHS Strategic Plan on the Prevention of Obesity in Texas. As outlined in the strategic plan, the first step in the prevention of obesity is public awareness, and that is where Building Healthy Families Initiative comes in. /2007/DSHS is planning to request nearly \$3 million from the Texas Legislature to implement the Strategic Plan for the Prevention of Obesity in Texas. The implementation will allow for continued surveillance, a media campaign, rigorous evaluation, and community capacity building.//2007//

/2008/SB 530 of the most recent Legislative Session establishes minimum daily physical activity requirements for certain public schools and requires an annual fitness assessment of all students in grades three through twelve. Results will be analyzed by the Texas Education Agency and shared with the statewide School Health Advisory Committee to assess effectiveness of programs.//2008//

3. Promoting and Integrating Mental Health and Substance Abuse Services into Primary Health Care Setting. In 2002, 1.5 million Texans suffered serious mental illness impairing their ability to function at work, school, and in the community. Only 25% of persons with mental illness obtain treatment, while 60%-80% of persons with heart disease seek treatment. Furthermore, as many as 40% of persons with serious mental illness do not seek treatment. Yet the recovery rate for mental illness overall is significantly better than it is for heart disease. Substance abuse data are somber: about half of all crime in Texas is related to substance abuse and committed by individuals younger than 25. Consistent with the National Initiative to Improve Adolescent Health by the year 2010, DSHS and Title V program are examining several avenues towards improving access to and utilization of quality mental health (MH) and substance abuse (SA) services for children, including children with special health care needs, adolescents, and pregnant women (in particular those with low income or with limited availability of health services) through integration of MH / SA in primary health care settings. To this end, a workgroup was established, consisting of DSHS executive managers and other external stakeholders: 1) to increase awareness of and promote utilization of Children's Medication Algorithm Project (CMAP) among primary care physicians, educators and parents; and 2) to ensure adolescent behavioral health screening in every primary care setting in Texas. Currently, the workgroup is focusing on a few potential primary care sites, such as Title V-funded MCH contractors, FQHCs, and rural health clinics, to participate in the pilot designed to integrate primary health care with behavioral health care effectively.

/2008/The Texas Adolescent Mental Health in Primary Care Initiative feasibility study is complete and partners will convene to plan the next phase of the large-scale comparative study.//2008//

4. Eliminating Disparities in Health Among Population Groups. In an attempt to address growing concerns about health disparities, the 77th Legislature passed HB 757 that established the Health Disparities Task Force. The task force is charged with consulting with DSHS: 1) to eliminate health and health access disparities in Texas among multi-cultural, disadvantaged, and regional populations; and 2) to reorganize DSHS programs to eliminate those disparities. The 2004 Annual Report of the Health Disparities Task Force to the Legislature focuses on five priority health issues: immunizations, obesity, tobacco, STDs, adequate prenatal care, and organizational programmatic and policy changes. Due to the recently completed health and human services consolidation, DSHS extends the public health framework to include mental health promotion substance abuse prevention, and the stigma associated with the treatment of mental illness and substance abuse to be more challenging. One challenge we now face is to address health disparities in a broader context. Some of the more striking disparities in mental health involve gender. Nearly twice as many women as men are affected by depression each year and more women than men attempt suicide. Yet, four times as many men as women die by suicide. Eliminating health disparities in Texas requires a commitment to identifying and addressing the underlying causes of higher levels of disease and barriers to access services in racial and ethnic minority communities. DSHS is committed to removing differences in health status, which we believe are simply unacceptable.

/2007/ DSHS is planning to request \$3 million from the Texas Legislature to implement a statewide community health disparities collaborative to conduct a comprehensive analysis to track the progress in elimination of health disparities; develop standards for communicating with all Texans on health issues; support the Health Disparities Council; and provide for a health disparities coordinator in each region. //2007//

/2008/House Bill 1396, 80th Regular Session transfers the Office for the Elimination of Health Disparities and the Health disparities Task Force from DSHS to the HHSC effective 9/1/07. The transfer was also highlighted as a recommendation in the organizational assessment of DSHS in December 2006. This change will provide more visibility to the office and enhance its ability to influence broader consideration of all health and human services within the HHSC enterprise.//2008//

5 & 6. Improving DSHS Ability to Respond to Disasters or Disease Outbreaks Whether They Are Intentionally Caused or Naturally-Occurring; and Improving the Efficiency and Effectiveness of DSHS Business Practices. Enhancing business practices and strengthening the state and local responsiveness to bioterrorism are two priorities for DSHS. As a tax-supported public service agency, DSHS is responsible for re-examining on an ongoing basis its business practices to assure proper stewardship of public funds. DSHS is committed to achieve all milestones included in its Business Improvement Plan by improving and establishing existing and new systems and controls for finance and accounting, budgeting, contract and grant management, and human resources.

Preparedness and response activities have become high priorities since the attacks of September 11, 2001. Ensuring a strong and flexible public health infrastructure is key to the ability of DSHS to react and protect Texans from both naturally occurring disease outbreaks as well as intentional threats, such as bioterrorism. DSHS is working with state, regional, and local partners to ensure a strong, flexible, and responsive public health preparedness.

/2007/ Preparedness and response have become even higher priorities for Texas since the occurrence of Hurricanes Katrina and Rita in August and September 2005. Over 450,000 Katrina evacuees landed in 202 of 254 Texas counties and Rita resulted in 3.2 million evacuees, 115,000 of whom went to 468 shelters. Recognizing the unique challenges encountered by pregnant women, infants, children, and adolescents during an emergency, Title V has begun to focus on the needs of these vulnerable groups during a natural or man-made emergency. //2007//

/2008/The Preparedness and Prevention Division of DSHS leads the efforts to work with the

Governor's Division of Emergency Management to prepare for and respond to disasters. DSHS is responsible for the emergency health and support functions of the state's emergency plan. Staff are receiving ongoing training to meet the National Incident Management Systems requirements. Drills, analysis of previous incidents, and other ongoing efforts to identify means of improving preparedness continue. In June 2007, state and county agencies and local jurisdictions focused on evacuation and sheltering coastal storm victims with special needs. DSHS staff are currently evaluating the exercise to be improve preparation. In addition, a report commissioned by DSHS to provide comprehensive assessment and strategic vision for guiding DSHS, public health partners, and other stakeholders in making future preparedness decisions is nearing completion. A draft version is posted at <http://www.dshs.state.tx.us/comprep/stakeholders/litaker.shtm> for public comment through 7/20/07.//2008//

//2009/ In October 2007, DSHS, along with several public and private partners, launched a statewide multimedia emergency preparedness campaign to help Texans prepare for emergencies. The "Ready or Not? HAVE A PLAN" or "¿Estás Listo? HAGAMOS UN PLAN" campaign is built upon an interactive Web site that can be used to create a family emergency plan, build a customized disaster supplies list and get information about preparing for a variety of threats. DSHS has held events across the state in local communities, such as Austin, Brownsville, Corpus Christi, Dallas, El Paso, Houston, Laredo, Lubbock, McAllen, Midland, Port Arthur, San Antonio, Tyler, and Waco to promote family preparedness. In addition, DSHS has used internal reviews to identify and implement improvements to agency response activities, including the creation of dedicated teams to address agency responsibilities for the state in times of disaster.//2009//

The success of the state's and the Title V Program's efforts to craft and implement a strategic direction depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women and children in the context of their communities. The following demographic, economic, and social trends provide an overview of some of these important characteristics for Texas.

Demographic Trends. According to the State Data Center and Demographer, by the year 2010 Texas' population is expected to grow from the current 22.5 million to 25 million. The population could be more than 51.7 million in 2040. Projected growth under all scenarios would be substantial, and in excess of Census Bureau national projections for the 50-year period from 2000-2050. Sixty-one percent of Texas' population aged 5 years and younger and 59% of the total population less than 18 years of age are non-Anglo. Texas is ranked 45 nationally in the number of persons aged 25 and older who completed high school, and of the 1.2 million students in public high school in 2000, approximately 12.5% dropped out. Texas socioeconomic and service structures will continue to be challenged by a population that is larger, older, and increasingly diverse. The Texas population is expected to experience the emergence of a new numerical majority. Population changes, coupled with Texas' size and complexity, will challenge Texas' resources during this century.

//2009/ Brief updates to demographic information regarding population growth and poverty rates are included with the map of Texas in Attachment III. A. Overview. //2009//

Economic Factors. Continuing the trend of the last couple of years, Texas' unemployment rate remained stable, albeit higher than that reported just a few years ago. According to the Texas Statewide Labor Market Analysis, the seasonally-adjusted unemployment rate in Texas for February 2005 was 6.1% with rates ranging from a low of 3.2% in Shackelford County (Region 11) to a high of 18.6% in Maverick County (Region 8). Ten of Texas' 254 counties (3.9%) reported double digit unemployment rates ranging from 10.0 to 18.6. East Texas counties, as well as the Texas-Mexico border, continued to have significant problems associated with unemployment. Most forecasts on Texas' economic picture indicate that the Texas jobless rate may have peaked and will likely improve in the near future.

//2009/ While the national unemployment rate for March of 2008 was 5.1%, the Texas rate was 4.3%. However, the impact of current challenges to state and local communities tied to increased fuel prices and lower economic growth is unknown at this time. //2009//

Current Poverty Rates. In 2004, 17.0% of Texas' population lived at or below poverty, showing an increase from the 14.7% reported in 2001. The issues of poverty continue to challenge state resources and impact overall health status. Hispanics were disproportionately the largest group living in poverty: among this group, the poverty rate was 59.8% in 2001, while they represented only about 35% of the general population. Anglos and others represented 26.4 of those living in poverty, and about 54% of the general population. African-Americans represented 13.8 of those living in poverty, but represent only 11.5% of Texas' general population. National estimates for 2003 indicate that 12.5% of the US population lives below poverty levels. The percentage of the population living below established poverty threshold is higher in Texas than in the nation (17% vs. 12.5%). However, poverty rates are lower in Texas compared with national rates for Anglos (7.3% vs. 10.5%) and Blacks (18.8% vs. 24.3%), and higher for Hispanics (25.2% vs. 22.5%). In Texas, those aged less than 18 years of age represent 41.6 of those living poverty, while those aged 65 plus represent 8.4% of those living in poverty. Forty-three percent of the total population living in poverty is employed, approximately 8.9% are unemployed, and 47.9 % are not in the labor force. Forty-nine percent have less than a high school education, with only 7.9% reporting a college or higher-level degree. Over 42% of those living in poverty have either both parents or the mother present in the home. Health care coverage remains a critical need for those living in poverty. According to the same reports, only 57% of those living in poverty in 2001 reported having some health insurance coverage during 2000.

Texas Health Insurance Coverage Rates. Many national sources continue to report that Texas has the highest rate of uninsured persons in the U. S. One out every 10 people without insurance in the U.S. lives in Texas. In 2003, the last year for which full year data is available, 5.5 million Texans or 24.6% of Texas' total population were uninsured. 2003 CPS estimates that 38.6% of Texas' Hispanics and 22.7% of Texas' African Americans were uninsured. Further, they estimate that 21.5% of all children under age 18, and 24% of all Texas women go without adequate or with no health insurance coverage. Educational attainment for this population is consistent with those reporting poverty status, with 38.3% of those without health insurance having less than a high-school education and approximately 10.7% reporting a college or higher-level degree. Addressing these issues relative to the uninsured and underinsured is a critical factor in improving maternal and child health outcomes.

Texas Uncompensated Care. The rise of health care costs and the fall of rates of insurance over the past several years in Texas have resulted in fiscal pressure on both state and local governments. The cost of uncompensated care absorbed by health care organizations for persons who are uninsured or unable to pay for healthcare keeps increasing over the years. In Texas, total uncompensated care increased 114% between 1993 and 2002. In 2002, Texas ranked highest among the seven most populous states in total uncompensated care reported by hospitals (\$6.1 billion), in per capita uncompensated care (\$282.50), and in the ratio of uncompensated care to gross patient revenue (8.2%). Several options are being examined to address the burden of uncompensated care. Those options can be summarized into the following broad categories:

- State initiatives to expand private health insurance coverage;
- Expansions of governmental insurance programs;
- Expansions of provider-based care, such as Federally Qualified Health Centers;
- State reimbursement systems for providers who incur costs; and
- State facilities that provide care for indigents, such as the University of Texas Medical Branch at Galveston or the Texas Center for Infectious Disease.

//2009/ HHSC submitted a Medicaid waiver request to the CMS on April 16, 2008 to address

challenges of existing health care system. The key element in the Texas plan is the creation of the Texas Health Opportunity Pool (HOP) trust fund that will serve as the funding source for targeted activities such as providing premium subsidies to low-income Texans, developing a catastrophic coverage program for parents and caretakers, and rewarding hospitals for innovative efforts to reduce uncompensated care. In addition, grants would be provided to improve coordination, provide services and/or support the infrastructure for a more effective and efficient health care system. A final element of the plan is to increase family coverage by blending funds from Medicaid, CHIP, HOP, and State Child Health Insurance Program (SCHIP) to enable families to buy into employer-sponsored coverage.

Title V staff will monitor progress of initiatives and assess the potential impact on access to care for the MCH population. Efforts are in response to direction provided in Senate Bill 10, 80th Legislature, Regular Session, 2007. More information regarding the efforts related to Senate Bill 10 may be found online at <http://www.hhs.state.tx.us/medicaid/reform.shtml>. //2009//

Health Professional Shortage Areas. Any reports addressing maternal and child health status in Texas must include a discussion on health care providers as there is a direct correlation to access to maternal and child health services and the availability of providers providing those services. Provider shortages in the state continue and, in part, frame the state's ability to impact maternal and child health status. In FY 2005, 51.6% or 131 of Texas' 254 counties are designated as HPSA for primary care and 79, or 31.1%, are designated as HPSA for dental care and treatment. The number of Medically Underserved Areas (MUA) remained stable at 177, while the number of partial county MUAs slightly increased to 88 (in 47 counties). Texas currently has 64 local health departments that receive state funding and approximately 78 local health departments that do not receive state funding. Of the 254 counties in Texas, approximately 150 (or 59%) have no local public health presence but receive public health services by DSHS regional offices.

/2007/ To address the need for qualified medical and dental staff, DSHS is planning to request \$35 million from the Texas Legislature to keep pace with compensation and benefits offered in the private sector and in other states. DSHS will engage medical residency programs and continue to use the J1 Visa Waiver Program to help rural and underserved areas recruit foreign physicians.//2007//

/2008/Budget requests to address agency recruitment of medical staff were not approved during the 80th Session. In FY08, DSHS will prioritize placement of qualified physicians in state hospitals through the Texas Conrad 30 J-1 Visa Waiver Program.//2008//

//2009/ In FY08, DSHS staff have been collaborating with HHSC to develop loan repayment opportunities that support recruitment efforts specifically linked to expanding the Medicaid provider base. Staff also began reviewing options to utilize community health workers or promotoras in emergency departments. //2009//

Key Initiatives and Summary of the Legislation Relating to Maternal and Child Health, including CSHCN. Key initiatives for CSHCN have begun in improving medical home services. Following an initial statewide kick-off conference in October 2003, there has been growing interest and awareness among stakeholders. A statewide Medical Home Workgroup (MHW) has been formed with regular meetings. The group has developed a strategic plan and provides continuing guidance to statewide efforts. The state applied and was accepted into the national Medical Home Learning Collaborative II. A state-level team works with three practice teams serving as medical home models. Paralleling the MHW, the CSHCN Services Program (SP) has established a Transition Workgroup, which has met several times and has a strategic plan. These groups planning efforts along with the strategic plans and initiatives of other formally established stakeholder advisory groups have been folded into the Title V CSHCN five-year needs assessment and planning process.

/2007/ Texas completed participation in the Medical Home Learning Collaborative II (MHLC II) in December 2005. The Texas State team facilitated improvements at the practice level and identified mechanisms to spread medical home activities at a state level. Parent partners in MHLCII served as change agents at the practice and state level. Two Texas practices, Baylor College of Medicine Transitional Clinic and Su Clinica Familiar, evidenced substantial improvements in all six medical home domains. Ongoing work is occurring through the MHW and the Transition Workgroup to promote and spread medical home practice and transition services in Texas for CSHCN and all children. //2007//

/2008/ The MHW continues to promote public awareness, training, and other efforts to increase medical homes for all children, including children with special health care needs. Workgroup members partnered with Texas Health Steps to develop an online Medical Home training for physicians and other health care providers and participated in the Center for Medical Home Improvement research project. CSHCN SP staff implemented a statewide teen transition event in conjunction with the Texas Parent to Parent Annual Conference. //2008//

/2009/ The MHW continues to promote public awareness, training, and other efforts to increase medical homes for all children, including children with special health care needs. The CSHCN Services Program and the Medicaid Program implemented a Clinician-Directed Care Coordination Policy that provides reimbursement for face-to-face and non-face-to-face care coordination for children in these programs. The CSHCN Services Program issued a Notice for Open Enrollment for Medical Home Supports requesting applications from Texas pediatric or family physician practices to implement practice-level supports to help improve the provision of a Medical Home for children and youth with special health care needs (CYSHCN) and their families in FY08 and FY09. Funding is limited to a maximum of \$10,000 per practice and is subject to the availability of state funds. These activities help support the development and promotion of medical homes for Texas children, including CSHCN. The CSHCN SP is collaborating with efforts to improve access to a dental home. DSHS activities include training medical home providers to do dental evaluations for infants as early as 6 months of age, apply fluoride varnish, and refer to a dental home for future dental treatments. //2009//

In addition, since the CSHCN SP no longer has a formal CSHCN Advisory Committee, the program actively looks for ways to engage stakeholders in the decision-making process. The program has strengthened ties with the Texas "Parent to Parent" organization and collaborates with their Champions for Progress grant. Parents of CSHCN in various geographic locations in Texas have become Family Voices representatives to improve statewide involvement of families in systems development. Regional social work staff and the program's community-based service contractors work to facilitate family access to services, promote family networking, increase family involvement in community service system development decisions, and obtain family feedback.

/2007/ Activities similar to FY05 continue. The CSHCN SP also collaborates with Texas Parent to Parent with their Family-to-Family Health Education Center grant awarded in FY06. Contractor family satisfaction is assessed, reported, and analyzed. Planning is underway for a survey to assess consumer satisfaction with the CSHCN SP health care benefits and the overall service system. //2007//

/2008/ Surveys to assess consumer satisfaction with the CSHCN SP health care benefits and the overall service system are underway in FY07. //2008//

/2009/ The CSHCN SP reviewed stakeholder input and recommendations from legislative and other reports developed by key statewide advisory councils/groups and collaborative initiatives in which DSHS has a partnership role related to children's services. The CSHCN SP is holding stakeholder focus groups at contractor site visits and events. Texas Parent to Parent staff is a Family Voices representative and attended AMCHP as a Texas Family Scholar. //2009//

On the MCH side, several initiatives are being implemented in collaboration with other public and private partners to improve access to and availability of care and to focus on prevention and education to prevent health problems and improve health status of the women and children in Texas. Examples are: 1) enhancing Texas's capacity to coordinate and integrate service delivery for all children under 6 years old; 2) providing local health care organizations with state funds to develop business plans and the infrastructure and capacity required of FQHC organizations (the initiative has resulted in more than 20 new or expanded existing FQHCs since its inception in FY 2003); 3) expanding the number of disorders screened in Texas and planning for the infrastructure and capacity required to serve newly identified children that will need confirmatory testing and follow up care; and 4) increasing access to mental health and substance abuse services for adolescents through a pilot project in which primary care physicians, family practitioners, and other medical professionals will be trained to screen, assess, and prescribe medicines to adolescents with minor mental health disorders and substance abuse problems.

*/2007/*Following the integration of mental and physical health services, DSHS has been successful in several national funding competitions in the area of mental health (Mental Health Transformation State Incentive Grant for \$2.7 million; Project InSight for \$17.5 million).

The Texas Adolescent Mental Health in Primary Care Pilot was initiated through funding from Title V Program and the DSHS Mental Health/Substance Abuse Division. The goal of this project is to test the effectiveness of behavioral health screening, assessment, treatment and/or referral of adolescents through primary care providers. Pilot sites included a military clinic, an FQHC, a public clinic, and a private clinic. The results of this pilot, which are expected in January 2007, are expected to inform broader system reform policy that may potentially impact medical school curricula and Medicaid reimbursement practices and address the shortage of mental health providers in rural and underserved areas.

/2009/ The feasibility study was completed and has been reviewed for future activities. In addition during FY08, a new pilot integrating mental health screening and onsite mid-level behavioral health practitioners into the normal workflow of primary care practices. //2009//

To assure that DSHS assumes a leadership role in suicide prevention, the Suicide Prevention and Surveillance Workgroup was formed and the position of Suicide Prevention Officer was created. In FY06, DSHS was awarded a suicide prevention grant from SAMHSA for approximately \$400,000. With this funding, DSHS will train health, school and community representatives to identify and refer youth who are at-risk for suicide and will raise awareness surrounding youth suicide.

The Title V Population-based Program released competitive proposals for FY06 and FY07 to fund projects for the highest-need areas of the state for prevention of teen pregnancy, sexually transmitted disease, low birth weight, and inadequate prenatal care. A total of 17 3-year projects were awarded for approximately \$3.3 million to deliver evidence-based programs intended to improve birth outcomes through focus on health disparities in high-need geographic areas.*//2007//*

/2009/ In FY08, requests for proposals were developed to address childhood obesity and injury prevention beginning in FY09. //2009//

The 79th Legislative Regular Session ended on May 30, 2005. DSHS tracked over 600 bills this session. DSHS staff analyzed and prepared fiscal notes for these bills, and many staff also served as resource witnesses at committee hearings. At the close of the 140-day session, less than 200 bills remained on the DSHS list. The information below provides a high-level summary of legislative bills impacting maternal and child health. Title V program plays an important role in assessing the impact and addressing the intent of each bill.

/2008/The 80th Regular Session ended May 28, 2007, and a summary of MCH related bills is included in the attachment for Section IIIB.//2008//

- Senate Bill (SB) 316: Requires DSHS to create an informational brochure about Shaken Baby Syndrome, perinatal depression, newborn screening, and immunizations, which would be posted on the DSHS website. The bill also requires that all hospitals, birthing centers, and midwives present new parents with written or verbal information about Shaken Baby Syndrome shortly after their child's birth. The bill also requires DSHS to make a printed version of the pamphlet available to physicians.

/2007/ The pamphlet, Information for Parents of Newborn Children, has been made available in English and Spanish through the DSHS website (http://www.dshs.state.tx.us/mch/Parents_of_newborn.shtm) and warehouse.//2007//

- House Bill (HB) 790: Requires DSHS to expand the number of disorders for which newborns are tested, to determine whether the activity should be outsourced, and to plan for the expansion to the full number of tests recommended by the American College of Medical Geneticists.

/2007/ See Section IIIB. Agency Capacity for an update on the Newborn Screening Program expansion. //2007//

- SB 419: Prohibits a physician from performing an abortion on an unemancipated minor without the consent of the minor's parent, guardian or managing conservator, or without a court order as provided under Chapter 33, Family Code. Title V currently produces and distributes informational materials that explain the rights of a minor under Chapter 33, which requires parental notification for abortion. The materials will be updated to include the new consent provision. DSHS also reimburses counties for the cost of judicial bypass proceedings, if the counties request it.

/2007/ A booklet, So You're Pregnant, Now What?, is under revision to reflect Texas' transition from parental notification for abortion to parental consent for abortion. This booklet will be distributed through the DSHS website and warehouse.//2007//

- SB 747: Requires HHSC to create a Medicaid waiver program expanding eligibility to women living at or below 185 percent of the federal poverty level for preventative health and family planning services, increasing access to these services and allowing the state to draw down additional federal Medicaid funding.

/2007/HHSC submitted a waiver on December 29, 2005 to the Centers for Medicare and Medicaid (CMS). Implementation of the waiver will be announced pending approval. Expanding Medicaid coverage for family planning to women at or below 185% of FPL will allow Title V dollars previously used to fund these services to expand family planning services for women with unknown immigration status and women either less than 18 or older than 44 years of age.//2007//

- HB 2475: Requires DSHS, in conjunction with the Cancer Council, to develop a strategic plan to eliminate mortality from cervical cancer by the year 2015. The strategic plan must take into account barriers to screening, current technologies and best practices, and identify gaps in service, and must be submitted to the Governor and members of the Legislature by December 31, 2006.

/2007/A steering committee headed by DSHS and the Texas Cancer Control Council was convened in December 2005 to oversee the Cervical Cancer Strategic Planning Initiative to produce a strategic plan to eliminate cervical cancer mortality by 2015. The plan is to be presented to the Legislature before the end of 2006.

SB 6. Transferred responsibility for the operations of the State Child Fatality Review Committee (SCFRC), which include local team development, report preparation, and strategic planning, from the Department of Family Protective Services to DSHS. Within DSHS, the Title V Office coordinates the operations of the SCFRC.//2007//

Texas Medicaid Program

Medicaid is a jointly funded state-federal program, established in Texas in 1967 and administered by HHSC. As of January 2004, there were 2,501,804 Medicaid recipients in Texas, as opposed to 2,683,168 recipients in June 2005, representing an increase of about 2%. Of these Medicaid recipients, 1,814,940, or approximately 68%, are aged 0-18. The Medicaid caseload indicates that about one in nine Texans (2.6 million of 22.5 million) relied on Medicaid for health insurance or long-term care services. Non-disabled children make up the largest share (64%) of Texas Medicaid clients. Of the 1,814,940 children 18 years old and younger enrolled in the program as of June 2005, about 1,732,551 (95%) were receiving TANF or SSI cash payments. Medicaid funds slightly above one-half of all births in Texas. In FY 2004, Medicaid paid for about 53% or 203,083 out of 379,671 births. In FY 2004, over half (56.6%) of the pregnant women in the Medicaid program are between the ages of 18 and 24. While private insurance companies can no longer exclude pregnant women seeking health insurance, many young pregnant women are less likely to be able to afford insurance. They are also more likely to work at low-level jobs that do not provide health coverage.

Texas currently provides services under the Medicaid managed care program in several service areas of the state, primarily centered in major metropolitan areas. These service delivery areas cover 43 counties. As of July 2002, a total of 767,581 clients were enrolled in Medicaid managed care. These clients were enrolled in either a health maintenance organization or the Primary Care Case Management (PCCM) model. As of July 2002, 66% of clients were enrolled in HMOs and 34% were in the PCCM plan. HB 2292 of the 78th Legislative Regular Session in 2003 directs HHSC to expand managed care throughout the state in order to obtain additional cost savings.

The expansion plan includes two managed care models: the fully capitated HMO model and a Primary Care Case Management (PCCM) model. In both models, members have a medical home through a primary care provider (PCP), from whom members receive primary care and obtain referrals to specialty care. In the HMO model, HMOs receive premiums from the state and pay providers negotiated rates to provide services to enrollees. In the PCCM model, PCPs receive a fee of approximately \$3.00 per member per month from the state for acting as the PCP for their Medicaid managed care patients, and provider claims are paid on a fee-for-service basis through the state's Medicaid claims administrator. Following are key elements of the expansion:

1. For acute care Medicaid (primarily serving low-income pregnant women and children):
The HMO model will be implemented in one new service area consisting of Nueces and eight surrounding counties (Health Service Region 11).

The PCCM model will be implemented in all remaining counties (197) without an HMO model. The implementation is on schedule for September 1, 2005. Through a transitional plan, the PCCM model will not be available in the new HMO service area and will be phased out of existing HMO service areas.

2. For integrated acute and long-term care Medicaid (serving aged and disabled Medicaid eligible clients):
The STAR+PLUS program, which is an HMO model that includes both acute and long-term care services, will be expanded to operate in all service areas in which the HMO model for acute care services will be available.

The recently completed 79th Legislative Regular Session appropriated about \$26.4 billion for Medicaid programs for the 2006-2007 Biennium. This represents an increase of \$4.9 billion in all funds. This funding anticipates increases in clients; restores certain services to adult Medicaid recipients; partially restores the Medically Needy Program; develops a comprehensive Medicaid education campaign for both providers and recipients; improves data analysis and reporting, and streamlines administrative processes; creates a Medicaid buy-in program for working individuals with disabilities who would qualify for Medicaid except for their earnings; establishes a five-year demonstration project to expand access to preventive health and family planning services for women 18 years and older; addresses cost growth in the program; and restores reimbursement rates to, or increases rates above, FY 2003 levels for long-term care services.

//2007/ A new federal law requires states to begin verifying the citizenship and identity of people applying for or receiving Medicaid. HHSC implemented protocols to ensure that this requirement will not be a barrier to access.//2007//

//2009/ In FY08, Medicaid reform activities have included several initiatives, including improving reimbursement for medical and dental providers, exploring waiver opportunities, and developing innovative ways to provide improved access to Medicaid benefits. HHSC developed an advisory committee consisting of the medical, dental, advocacy and academic communities to advise HHSC on which projects to fund with the \$150 million appropriated for strategic medical and dental initiatives to improve access to health care for children enrolled in Medicaid. More information on the current activities can be found on the HHSC Medicaid web page: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/frew.html //2009//

Title XXI: Children's Health Insurance Program (CHIP)

With the passage of Title XXI, Texas began planning and implementation of a state children's health insurance program. Texas CHIP is a state-designated program targeted to children ages 0 through 19 years of age at or below 200% FPL who are not otherwise eligible for Medicaid. Texas also covers legal immigrant children who are ineligible for CHIP under federal law because of their immigration status. Because these children are not eligible for the federal CHIP match, their coverage will be financed solely with state revenue.

Due to planned changes in the federal funding for state CHIP and other budgetary concerns, the 78th Texas Legislature in 2003 directed several significant changes in Texas CHIP policy. These changes include: 1) decreasing the continuous coverage period from 12 months to six months; 2) increasing premiums for families above 100 percent of the FPL and cost-sharing for families below 185 percent of the FPL; 3) elimination of income deductions for items such as child care costs; 4) implementing a 90 day waiting period for coverage; and 5) several specific exclusions also were made from the benefit package and include dental, chiropractic and allergy services; vision care; and eye glasses. After these policy changes were implemented, the number of children enrolled in CHIP in Texas declined from 507,259 in September 2003 to 326,809 by May 2005, or about 36%. Texas CHIP reports that the three largest reported reasons for disenrollment are failure to complete the renewal process (38% of all disenrollment), mid-term status change resulting in enrollment in Medicaid (24% of all disenrollment), and families found ineligible after submitting renewal application (18% of all disenrollment). Any reductions in caseload in CHIP coupled with changes in Medicaid continue to impact negatively Texas Title V program's recipients.

However, the effect of these changes in eligibility requirements on enrollment should be viewed in a historical and national context. Prior to this decline in enrollment, Texas had engaged in aggressive outreach efforts to increase the number of children enrolled. In the first year of operation, the Texas CHIP program grew to cover over 300,000 children, and by year two it covered over a half million children. Also, the decline in enrollment in Texas occurred during a time when the federal funding for SCHIP was decreasing and when many states were experiencing fiscal constraints. The decline in Texas' enrollment coincided with those of 11 other states and the District of Columbia. Similar to Texas, many states implemented SCHIP policy changes that impacted enrollment.

Although disenrollment from CHIP in Texas and in other states could be the result of changes in employment, income, access to employer-sponsored insurance, or other factors, there is a concern among advocates and policy analysts that administrative barriers, such as re-enrollment procedures, increased cost-sharing, and confusion among parents of enrolled children are significant causes of disenrollment. As a result, an analysis of disenrollment patterns in Texas CHIP was conducted by surveying families. The major findings are the following:

- Of those children who disenrolled from CHIP, the distribution of race and ethnicity is very

similar, indicating that there was no disproportionate disenrollment of any particular racial or ethnic group.

- the majority of those families who obtained coverage for their children post disenrollment enrolled their children in Medicaid, thus, remaining on a public insurance program.
- Fewer Hispanics (40%) obtained insurance upon disenrolling when compared to White non-Hispanic families (57%) and Black non-Hispanic families (56%).
- The disenrollees' age is another potential area of concern. Children who disenrolled were somewhat older than those remaining enrolled.
- Eighty-eight percent of families were aware of the renewal process and 80% thought the process was easy.

When developing future policy, HHSC should consider the following strategies to: 1) increase outreach and education efforts with Hispanic families; 2) coordinate efforts between CHIP and Medicaid programs since a small percentage of families indicated that they had no coverage because they were told they qualified for Medicaid but later found out they were not eligible; 3) encourage parents of healthy children to maintain insurance coverage in order for these children to access preventive care services, including early detection of health problems, vaccinations, and routine screening procedures; and 4) ensure adolescents maintain coverage since this age group is at high risk for morbidity and mortality due to risk-taking behaviors.

The recently completed Texas 79th Legislative Regular Session in 2005 appropriated \$1.4 billion for CHIP. Funding covers projected increases in client caseloads, addresses cost growth, adjusts assumptions on client cost sharing, restores dental, vision, hospice, and mental health benefits. In April 2005, HHSC solicited competitive proposals from vendors to provide dental care services statewide. Vendor proposals were due June 15, 2005, and program staff will spend the summer evaluating the proposals to make a tentative award announcement in August 2005 for a starting date for services on December 1, 2005. In addition, pending approval by the federal government, CHIP coverage will expand to cover eligible children during the prenatal period. This expansion will provide prenatal care to women not eligible for Medicaid due to their immigration or financial status. If approved, a large percentage of the women currently receiving prenatal care under Title V will receive care through CHIP, freeing up funds to focus on other areas.

//2007/ Texas became the 9th state to successfully expanded CHIP to provide health benefits, specifically prenatal and postpartum care, to unborn children of women who are currently not Medicaid-eligible due to immigration status and to women between 186% and 200% of FPL. CHIP Prenatal Care Program (PCP) will begin January 1, 2007. Major challenges include provider credentialing with HMOs, the absence of retroactive coverage within CHIP PCP, and the credentialing and use of mid-level providers. Title V and HHSC policy staff are meeting to overcome these challenges. With the expansion of CHIP funding, Title V funds, which previously funded these activities, can be dedicated to other MCH, such as postpartum depression and dental care for pregnant women.//2007//

//2008/On 1/2/07, CHIP perinatal coverage began and Title V has continued to provide prenatal care through existing contractors to assist in the transition of the new service.//2008//

//2009/ In FY07, HHSC reported that 39,972 women received prenatal care through CHIP in the first 8 months of the program. Title V-funded contractors provided prenatal care services to women while eligibility was determined. Although Title V expenditures for prenatal care services decreased an estimated 34%, agency leadership approved plans to continue the "gap-filling" role in FY09 to support early access to care. //2009//

Movement of Children Between CHIP and Medicaid.

Once a child has left either CHIP or Medicaid, HHSC examines records for the following year to find out whether the child enrolled or re-enrolled in Medicaid or CHIP. The analysis of the movement of children between Medicaid and CHIP revealed that in FY 2004:

- a. Of the 379,009 children who left CHIP, 158,378 or 42% enrolled in Medicaid and 73,980 or 20% re-entered CHIP during the next 12 months.
- b. Of 887,224 children who left Medicaid, 91,090 (10%) enrolled in CHIP and 364,526 or 41% re-entered Medicaid during the next 12 months.

Data are not available to show the number of children who obtain private insurance after leaving CHIP. However, a telephone survey of families who recently disenrolled from CHIP, conducted in 2004, indicated that 16% of these children obtained coverage through employer-based insurance or other sources, such as the military.

//2007/ In 2006, Medicaid and CHIP enrollment declined. A possible explanation for this decline is the implementation of new regulations requiring proof of residency and income. These new regulations may have confused applicants leading to inadvertent exit. However, these new regulations also allowed HHSC to identify families whose income exceeded eligibility. HHSC is working to ensure that regulations do not pose barriers to enrollment state-supported insurance programs.//2007//

//2009/ As of July 2008, Texas has enrolled 463,939 children in CHIP, and increase of over 50% in twelve months. While no significant changes in Medicaid enrollment have occurred, preliminary data for July 2008 indicate that over 1.8 million children under 19 and 110,00 pregnant women were eligible for Medicaid.

Of note, HHSC awarded \$7.8 million in grants for a new program that will pair nurses with low-income, first-time mothers to improve prenatal care and provide one-on-one child development education and counseling. The Nurse-Family Partnership will begin in FY09 and Title V will support linkages to available MCH services.

//2009//

An attachment is included in this section.

B. Agency Capacity

I. MCH Population

Because the Title V program primarily provides MCH services through contracts with local providers, it is critical that the agency has the capacity to ensure that these providers execute competently. Three areas of the agency provide the staffing, policies and guidelines, training and technical assistance, and quality assurance needed to support providers. Two of these areas, the Preventive and Primary Care Unit (PPCU) and the Performance Management Unit (PMU), are located in the Family and Community Health Services (FCHS) Division. The third area encompasses the health services regions located throughout the state. PPCU oversees the development of clinical policies and operational processes to assist contractors in delivering clinical services. Medical consultant Dr. Janet Lawson, an obstetrician/gynecologist, provides leadership in the development and clarification of clinical policies and protocols for community health services programs. Other staff members maintain expertise in national health standards, guidelines and best practices and provide clinical and technical support services to contractors. The unit also develops and implements professional education opportunities for clinical and administrative contractor staff to support service delivery. Clinical staff review and approve local clinical protocols, standards and procedures and provide support to required advisory committees, such as the Information and Education Committee for Family Planning and the Advisory Committee for Breast and Cervical Cancer Control.

//2007/ Dr. Janet Lawson is now the Director of DSHS Regional and Local Health Services (RLHS). In this capacity, she serves as a liaison between DSHS programs such as Title V, the Regional Directors who oversee the 11 health service regions (HSRs), and the local health department directors. FCHS is preparing to fill Dr. Lawson's position to ensure that medical expertise for MCH is provided.

The DSHS Medical Council was created in July 2005 to serve as a forum for the development of medical policy and best practices for agency medical and clinical staff. The Medical Council is comprised of twelve physicians appointed by the Commissioner of DSHS to serve for two years. These physicians represent both public and behavioral health. The Medical Council sponsored a continuing educating conference, Perspectives in Health: Public Health & Mental Health Working Together for a Common Goal, in May 2006.

DSHS has undertaken multiple activities to improve preparedness and disaster response since the occurrence of hurricanes Katrina and Rita in 2005. A Medicaid waiver provided flexibility to simplify eligibility for Katrina victims and to provide up to five months of assistance and to provide services such as mental health and substance abuse services. The magnitude of evacuee mental health issues altered the landscape of behavioral health challenges that Texas already faces, increasing the urgency for DSHS to create a cohesive approach to addressing physical and mental health. DSHS participated in a statewide hurricane response exercise in May 2006 with the focus of identifying, evacuating and sheltering persons with special medical needs. The Multi-Agency Coordination Center (MACC) was activated and staffed with personnel from DSHS and the Department of aging and Disability Services. Other participating agencies included the Texas Nurses Association, the Texas Hospital Association, the Texas State Board of Pharmacy and other entities critical to a successful emergency response. The Hurricane After Action Report highlighted areas for improvement when confronting future natural disasters and emergencies, including improve/clarify roles and responsibilities, consider the medical needs of evacuees along evacuation routes, and the need for a review of evacuation plans. Title V child and adolescent health coordinators will provide DSHS leadership with directions and focus on the needs of children and adolescents in future emergencies. To ensure appropriate responses to future emergencies, DSHS is planning to request \$4.9 million from the Texas Legislature to create a contingency fund for preparedness, including evacuation and shelter support; mobile laboratory for on-site radiological responses; improved statewide communication during health emergencies; and enhanced surveillance. //2007//

The PMU has primary responsibility for quality assurance (QA) and quality improvement (QI) activities for contracted community health services, including Title V-funded services. The QA activities ensure that contractors comply with program rules, policies, and procedures for clinical and administrative areas. The QA site visits are based on risk assessments, and contractors are required to submit corrective action plans for areas found to be out of compliance during the review. Within the PMU, Quality Management Branch (QMB) staff coordinates the development of QA review tools. The QI activities focus on an analysis of QA results and outcomes. Common performance problems are tracked and reviewed with relevant staff. Research is conducted for national community health services standards, and staff develops QA targets for performance issues to assist with contract management and to ensure that quality services are provided. /2007/ A service improvement process is currently underway within DSHS to centralize the five major contract processes of planning, procurement, management, monitoring and closeout at the agency level and to streamline division processes that contribute to the centralized processes. Title V staff participate in the FCHS Division contract transition workgroup to provide input to the agency-side workgroup. //2007//

DSHS and the Title V program operate within a structure defined by 11 health service regions for the provision of essential public health services to all Texans. The Title V program funds several positions based in regional offices to provide: 1) public health services, including core public health services and direct health care, in areas with no local health department (141 out of 254 counties have no public health presence); and 2) technical assistance, contract management, and quality assurance and quality improvement activities for all Title V-funded providers in their assigned regions. Consistent with Title V priority needs and related activity plans for FY 06, Title V program areas work with each public health region to develop, implement and monitor service level agreements (SLAs) in the areas of population-based services, quality assurance, vision and hearing, contract monitoring, and direct services. Each SLA amounts to a contract between the State Title V Director Office and each PHR and provides quantifiable time-specific performance

measures, activities, and outcomes that each Title V-funded public health region agrees to complete during specified timelines. Title V central and regional work together to develop and finalize the SLAs.

/2007/ In the agency structure, HSRs function within RLHS, currently located within the scope of the Center for Program Coordination and reporting to both Deputy Health Commissioners. In the fall of 2006, RLHS is to be reconfigured as a fifth Division within DSHS and will report directly to the Commissioner of Health. HHSC Executive Commissioner, Albert Hawkins, approved the pending reconfiguration in August 2005. Due to the significance of the HSRs' role in assuring the essential public health functions, DSHS assembled an internal work team to examine the agency's role in assuring essential public health standards. Input was sought from an array of public health partners that included the Title V Director. Although the work is ongoing, progress was achieved in defining DSHS's role in assurance of the standards, identification of factors affecting the costs of the standards, and identification of ways to strengthen linkages between mental health, substance abuse and the standards. With declines in federal funds that support RLHS, DSHS is planning to request \$12.4 million from the Texas Legislature to ensure that these services can continue. //2007//

/2009/ With implementation of CHIP Perinatal and the Women's Health Program in FY07, regional DSHS activities were reassessed to determine the most efficient use of Title V resources. In FY08, staff in HSRs 4/5N, 6/5S, 9/10, and 11 worked with Title V to transition from providing direct health care services to population-based or infrastructure building services. All HSRs have developed plans for population-based activities based on unique needs identified through analysis of regional data. Activities include child injury and fatality prevention, adolescent pregnancy prevention, and maternal and child overweight and obesity, among others. HSRs submitted quarterly reports to the Office of Title V and Family Health for review and planning purposes.//2009//

A number of overarching programs areas exist within DSHS to provide infrastructure and support for Title V service delivery. With the reorganization of the agency came three new offices, the Center for Policy & Innovation, the Center for Program Coordination and the Center for Consumer & External Affairs.

The essential functions of the Center for Policy & Innovation (CPI) are to provide organizing frameworks for service and policy innovation at DSHS. This includes establishing frameworks for inter-agency collaboration and rules development, review and revision. CPI responsibilities include developing methods that allow integrated funding across programs to provide cohesive services targeted to specific populations; facilitating a consistent communication bridge with agency leadership; increasing meaningful consumer involvement to broaden the range of possible partnerships; and building systems of care focusing on customer needs.

The Center for Program Coordination (CPC) strives to improve the overall performance of DSHS as well as the connections between the agency and its employees. Central to this work is the DSHS Workplace Improvement Plan, which focuses on agency strategic priorities in three areas-- attracting and developing the best public health and behavioral health services; encouraging innovation and results-oriented government performance; and engaging employees in improving agency business and program practices. CPC has four primary functions. The first is program integration and coordination within DSHS and the HHHS umbrella and other related state agencies. The second is business process improvement, including mapping agency business practices, making recommendations for improvements, ensuring the use of consistent standards and practices, training on project management tools; and evaluating and maintaining benchmarks for department operations and service delivery. The third is leadership and management development, and the fourth is workplace improvement, including implementing the DSHS Workplace Improvement Plan.

/2007/ The CPC continued to facilitate the DSHS process for workplace improvement throughout

2006. Last fall, the DSHS Commissioner approved two agency-wide workplace-improvement initiatives. The first, "3 in 30," refers to identifying three priorities from the 14 recurrent themes, which was completed in December 2005 by DSHS organizational areas (divisions, regions, hospitals, and centers). The DSHS leadership team also developed strategies for three agency-wide priorities identified by senior management, regional directors, and hospital superintendents. The second initiative is "Success in 60." Over the first 60 days of 2006, each DSHS organizational area developed a work plan with strategies and activities in the three areas identified for improvement. The goal was for identification and initial implementation of strategies to be completed by March 1, 2006; however, some strategies may be longer term.

Other significant CPC activities include the hiring of a staff position in 2006 to oversee DSHS leadership and management development, development and implementation of a new employee orientation to be piloted in June 2006, and coordination for the first State Public Health System Assessment Conference, scheduled for July 2006. An expected outcome from the conference will be to develop and implement a public health system improvement plan based on strengths and weaknesses identified in the assessment. //2007//

//2009/ In FY08, the CPC and CPI were merged into the Center for Program Coordination, Policy & Innovation (CPCPI) to improve efficiency. An additional position was identified to provide agency wide coordination of program activities specifically related to Medicaid and to support collaborative efforts in those common areas with HHSC. //2009//

The Center for Consumer & External Affairs (CCEA) provides centralized support to the DSHS Advisory Council; maintains stakeholder relations; provides a central location for public input; evaluates and analyzes customer satisfaction; and coordinates responses to inquiries to DSHS and among other health and human service agencies. The Center also serves as the liaison for governmental affairs, analyzes legislation; processes consumer complaints; and coordinates responses to media inquiries.

//2009/ On 9/1/07, the Office of Priority Initiatives Coordination was established to provide support to the DSHS Commissioner's office to ensure that legislative mandates, exceptional item funding, and agency priority projects are identified, resourced, and managed appropriately. //2009//

Additional program areas that provide systems capacity to Title V include: the Birth Defects Epidemiology and Surveillance Registry; the Promotora/Community Health Worker Program; the Laboratory Facility; the Center for Health Statistics; the Office of Border Health; the Office for the Elimination of Health Disparities; and the School Health Network.

The Birth Defects Epidemiology and Surveillance Registry collects data on birth defects throughout Texas. The data are used to identify patterns and differences around birth defects and the affected populations, conduct cluster investigations, contribute to national data collection efforts, evaluate potential environmental hazards and provide referral information for children and their families. The Research Center fosters collaborative research in finding preventable causes of birth defects.

In an effort to build an effective, culturally competent public health workforce, the 77th Texas Legislature codified the training and certification process for becoming a promotora/community health worker. Promotoras provide outreach, health education and referrals, often in a peer environment. The DSHS Promotora Program was charged with developing and operating the training and certification processes. At this time, there are 500 certified promotoras operating in 53 counties with all but one HSR represented. Use of promotoras is an emerging best practice for health education and counseling, and is a widely accepted means of disseminating maternal and child health information.

//2007/ The DSHS Promotor(a) or Community Health Worker Training and Certification (CHW)

Program convened a workgroup consisting of DSHS programs to collaborate with the CHW Program in developing a strategic plan to increase the program's effectiveness. The workgroup charge is to identify resources to support the mission and goals of the CHW Program and allowing it to reach its full potential; developing a strategy that facilitates the program functions of building capacity and infrastructure for direct and population-based services and increasing access to primary and preventive health care; and developing a plan to effectively link the resources, (promotores and CHWs), with the agencies, employers, and communities. The workgroup includes representatives from the three DSHS Divisions: Mental Health and Substance Abuse Services, Family and Community Health Services, and Prevention and Preparedness Services. Both the Texas Title V director and the perinatal coordinator represent Title V. Promotora/CHWs are viewed as an effective means of carrying out population-based activities as well as complementing fee-for-service activities. //2007//

//2009/ In summer of 2007, the DSHS Promotor(a) or CHW Training and Certification Program was transferred to the Office of Title V and Family Health. //2009//

The DSHS laboratory facility conducts tests for large health screening programs and for public health programs, including clinical testing for infectious diseases and environmental testing for chemical contaminants. Routine activities include providing laboratory testing for the newborn screening program, the Texas Health Steps Program, and women's health services including cervical cancer screening; providing prenatal screening to determine the risk of Down's Syndrome, Trisomy 18, and neural tube defects. The laboratory provides selected clinical testing free-of-charge to all Title V-funded providers.

//2007/ November 1, 2006, is the targeted implementation date for the Newborn Screening (NBS) Program expansion. The number of disorders will increase from five to 27 and will include but not be limited to testing for four Fatty Acid Oxidation disorders, nine Organic Acid disorders, and Biotinidase Deficiency. As a result of the study on outsourcing, lab services for NBS will remain in-house with DSHS. Tandem mass spectrometry (MS/MS) technology will be utilized and 10 MS/MS instruments will be installed as part of a laboratory retrofit to accommodate the instruments. Increased capacity to meet the need for expanded case management throughout the state will include 16 FTEs in the health service regions and additional central office staff. Outreach and provider education, including continuing education credits for providers, will be enhanced. //2007//

The Center for Health Statistics (CHS) is the DSHS focal point for the collection, analysis and dissemination of information to improve public health in Texas. CHS evaluates existing data systems; defines data needs and analytic approaches; adopts standards for data collection and dissemination; and coordinates, integrates, and provides access to specific CHS capabilities, including GIS; research design; health surveys; community assessments; and analytical methods. CHS coordinates and maintains health information web resources and responds to data requests. CHS also coordinates the collection and analysis of the BRFSS information for many Texas communities. The DSHS library, also part of CHS, provides health education and information services and resources to DSHS staff and consumers, including contractors.

The Office of Border Health (OBH) and the Office for the Elimination of Health Disparities (OEHD) provide critical support services for programs working to meet the needs of a state as populous and diverse as Texas. Thirty-two of Texas' 254 counties are defined as border counties. OBH is part of a bi-national effort to identify and prevent consumer, environmental and community health hazards along the Texas-Mexico border in coordination with local communities and U.S. and Mexican health entities. The Office promotes and coordinates public health issues with entities on both sides of the border; acts as the Texas Outreach Office for the U.S.-Mexico Border Health Commission; and works to inform, educate and mobilize community partnerships around health concerns.

OEHD supports the efforts of the Health Disparities Task Force, created in the 77th Legislative

Session, to eliminate health and health access disparities in Texas among multicultural, disadvantaged and regional population. The work of the OEHD and the Task Force has concentrated on six health topics: childhood immunization, obesity, physical activity and fitness, tobacco use, responsible sexual behavior and adequate prenatal care. In its 2004 report, the Task Force made a series of recommendations around each of these topics including increasing state funding and other resources to address them, expanding health promotion efforts and prevention programs and strengthening partnerships inside and outside DSHS. The Task Force also recommended maintaining the elimination of health disparities as an agency focus; the implementation of an internal workgroup for the elimination of health disparities; and the development of a cultural competency training program for DSHS staff and providers that could be replicated in other health and human service agencies. Both the OEHD and the Task Force work to guide and support DSHS programs in their efforts to eliminate health disparities related to their focus areas.

/2008/ Effective 9/1/07, the OEHD and the Task Force will be placed in the HHSC and will work with all health and human services programs.//2008//

/2009/ The OEHD has continued efforts to address efforts to improve services across health and human service agencies, providing learning opportunities to agency staff. The Title V Perinatal and Women's Health Coordinator has worked with OEHD and will attend conference in Atlanta to address health disparities in Women's Health. //2009//

The Title V School Health Program supports the development of comprehensive school health education and school-related health care services statewide through two major program areas: school health network and school based health centers. The program provides start up grant funding for communities to establish school-based health centers to provide preventive and primary health care services on school campuses to a target population of medically underserved school age children and adolescents. In addition, the program funds the Texas School Health Network, which consists of a School Health Specialist in each of the state's 20 Regional Education Service Centers (ESCs). The Specialists serve as a coordinating point and collaborative catalyst that promotes a healthy school environment and the healthy behaviors of all students and personnel. Many other programs within DSHS utilize the skills of the Specialists to promote their special initiatives but each Specialist tailors his or her program to concentrate on those needs/issues identified by the local school districts and the community.

/2009/ Title V Child Health Coordinator participated in strategic planning with the School Health Program Staff and representatives from the ESCs in April 2008 to provide information on the Title V activities and seek feedback for ongoing collaboration. The following topics were identified as the focus for the upcoming year: educational and prevention efforts related to reducing teen pregnancy, injury and violence, obesity and diabetes, suicide and substance abuse.

In addition to the ESC Specialists, Title V provides funds to be used in school based health clinic projects. In FY07, the School health program provided funding for four independent school districts (ISD)s: Socorro and Tornillo ISDs in El Paso County; LaMarque ISD in Galveston County; and Bangs ISD in Brown County. In FY07, there were a total of 24 campuses served and 5,675 enrolled clients. Over 7,000 primary and preventive care visits were provided by the clinics.//2009//

/2007/ In 1995, Texas enacted legislation establishing the State Child Fatality Review Team Committee (CFRTC or Committee) and authorizing counties to form local and regional Child Fatality Review Teams (CFRT). Senate Bill 6, 79th Legislative Session, amended sections of the applicable code, Family Code 264, Subchapter F (SS264.501 - SS264.515); most notably moving support and coordination of the State Committee and CFRTs from the Department of Family and Protective Services to the Department of State Health Services. The FTE (Child Fatality Review Coordinator) to implement the legislative requirement now resides in the Title V Office. The Child

Fatality Review Coordinator works collaboratively with staff from DSHS' Vital Statistics Unit and Epidemiology and Surveillance Unit.

The State Committee is a multidisciplinary group comprised of members throughout Texas. Its mission is to reduce the number of preventable child deaths and its purpose is threefold:

- To develop an understanding of the causes and incidence of child deaths in Texas;
- To identify procedures within the agencies represented on the Committee to reduce the number of preventable child deaths; and
- To promote public awareness and make recommendations to the governor and the legislature for changes in law, policy, and practice to reduce the number of preventable child deaths.

CFRTs are multidisciplinary, multiagency working groups that review child deaths on a local level from a public health perspective. By reviewing circumstances surrounding child deaths, teams identify prevention strategies that will decrease the incidence of preventable child deaths. The review process also provides an opportunity for an ongoing needs assessment for Title V.

Texas CFRTs vary in size and the number of counties for which they review child deaths. Several teams each review deaths for one county while others review deaths for two or more. The largest number of counties a single Texas team covers is 26. Currently there are 46 active teams that cover approximately 80% of the Texas population. DSHS plans to expand the number of local teams to enable a complete review of all infant and childhood deaths in Texas. //2007//

***/2009/ The annual report for 2007 is located online at the following web page:
<http://www.dshs.state.tx.us/mch/pdf/Texas%20Child%20Fatality%20Review%20Team%20Annual%20Report%202007.pdf> //2009//***

/2008/In addition, at DSHS, Title V is working with the Mental Health and Substance Abuse Division and Texas Tech University to provide continuing support to the Texas Adolescent Mental Health in Primary Care Initiative (TAMHPCI). The goal is to improve the mental and physical health of adolescents through private and public partnerships and sustainable system changes and a feasibility study is near completion. Initial results are very promising and all indicators point that with slight adjustments in implementation, the TAMHPCI model could be instrumental in transforming not only behavioral health care, but also in implementing evidence-based protocols for other public health concerns.//2008//

/2009/ The feasibility study was received and has been under review to identify next steps and potential inclusion in other DSHS integration activities in FY09. //2009//

II. CSHCN

CSHCN SP provides a comprehensive array of health care benefits (HCB) including: evaluation and diagnosis; physician visits; inpatient and outpatient hospital services; orthotics and prosthetics; medical equipment and supplies; nutritional supplements and counseling; medications; speech, language, physical, and occupational therapy; meals, lodging, and transportation to receive medical treatment; and family supports to CSHCN who meet a broad functional definition of "children with special health care needs," not just children with specific diagnoses, and adults with cystic fibrosis. The CSHCN SP provides health care benefits that are not covered by other third party payers. The program is the payer of last resort, after Medicaid, CHIP, and private insurance. The CSHCN SP enrolls and reimburses individual HCB providers throughout the state on a fee-for-service basis. Currently, due to budgetary constraints and the fact the CSHCN SP is not an entitlement program, the CSHCN SP continues to have a waiting list for HCB, which was instituted in October 2001.

/2007/ The CSHCN SP waiting list continues, however, clients are released as funds are available. The program has developed policy to allow coverage for clinician-directed non face-to-face care coordination to help reimburse for medical home services.

Title V CSHCN staff are also active in numerous state and national associations and advisory groups in order to retain subject matter expertise in CSHCN issues. Some of these affiliations

include AMCHP, the Children's Policy Council, the Texas Council on Developmental Disabilities, the Texas Pediatric Society, the Community Resource Coordinating Groups State Council and the Texas Center for Disability Studies. //2007//

/2008/ The CSHCN SP continues to have a waiting list and clients are released as funds are available. The policy to allow coverage for clinician-directed non face-to-face care coordination is anticipated to be implemented by Medicaid and the CSHCN SP on 9/1/07. Staff participation in stakeholder groups continues. //2008//

/2009/ The CSHCN SP continues to have a waiting list and clients are released as funds are available. CSHCN SP provider reimbursement rates were raised on October 1, 2007 to equal new Medicaid rates in an effort to improve recruitment and retention of providers. In the 80th Legislative Session, the CSHCN SP received special initiative funding to remove clients from the waiting list. Using both base funding and the special initiative funding, nearly 800 clients were removed from the CSHCN SP waiting list between September 2007 and April 2008 to begin receiving comprehensive, on-going health care benefits. //2009//

CSHCN SP provides family support services (FSS), such as respite and vehicle and home modifications, to its health care beneficiaries. When there is a waiting list for HCB, as there is now, FSS is available only to CSHCN SP clients who are not on the waiting list and who are at risk of out of home placement or whose FSS coverage would result in cost-savings for the program.

/2007/ FSS policies and procedures were updated and service clarifications made in FY06. //2007//

At the end of February 2005, 827 CSHCN were on the waiting list for HCB. The number of clients on the waiting list varies due to the program's continuous receipt of applications and the removal of clients from the waiting list when the program's financial projections demonstrate the capacity to serve more clients. Budget alignment mechanisms have been put in place through the public rule-making process to enable the program to offer as many services as possible to individuals eligible for the program. Depending on budget projections, the program may offer limited services for limited time periods to clients on the waiting list for HCB.

/2007/ At the end of FY05, the CSHCN SP had funds available to offered limited services for a specified time period to clients on the waiting list for CSHCN SP health care benefits. As of February 28, 2006, 747 were on the waiting list for CSHCN health care benefits. As of February 28, 2006, 717 CSHCN had been released from the waiting list. //2007//

/2008/ As of February 28, 2007, over 1100 children were on the waiting list for CSHCN health care benefits. 143 CSHCN had been released from the waiting list in FY07 as of February 28, 2007. //2008//

In addition to HCB, the CSHCN SP annually provides extensive case management services throughout the state to more than 26,000 families and their CSHCN through DSHS Regional social work staff. Through service contracts with community-based organizations additional case management, FSS, and clinical care are provided to over 15,000 families and their CSHCN each year. Case managers (both staff and contractors) provide a critical statewide infrastructure for continuous efforts to: improve awareness of and access to the CSHCN Services Program health care benefits; coordinate state and community-based service systems; and achieve the Title V performance measures.

/2007/ For FY06 the CSHCN SP improved data collection systems to provide more accurate counts of CSHCN and their families receiving case management through CSHCN SP regional staff and case management, family support and clinical services through CSHCN SP contractors. These changes to reduce data duplication and clarify definitions may impact the reported number

of families served. //2007//

//2009/ The CSHCN SP disseminated a new brochure and poster providing an overview of program benefits. //2009//

CSHCN SP staff work closely with other programs, agencies, organizations, stakeholder groups, and advisory committees/councils to improve the systems of care for CSHCN and their families and promulgate the importance of statewide collaboration to address and make progress toward the Title V CSHCN performance measures. Key stakeholder groups have addressed and incorporated the Title V CSHCN performance measures in their formal recommendations to the Texas legislature. Recent consolidation of programs within the former Texas Department of Health with the state mental health and substance abuse services to form the new DSHS offers an infrastructure and capacity that will facilitate increased collaboration among these programs and service delivery systems.

Culturally Competent Care

Current activities in all Title V program areas include an expectation that all staff have a working knowledge of cultural competence and the ability to conduct their work in a manner that shows consideration for racial and ethnic differences and for clients with physical, emotional and mental disabilities. People First language is used and all materials are made available in English and Spanish, and often other languages. Title V works to ensure cultural competence from its contractors through contract assurances, training and quality assurance monitoring. Title V Request For Proposals (RFPs) include a set of assurances and certifications towards limited English proficiency, interpreter services, and non-discrimination to which each contractor agrees to abide. Title V-funded contractors are supplied with a self-evaluation checklist for compliance with ADA/Section 504 policies and procedures.

Title V program areas staff also have access to translation services in the DSHS Center for Consumer and External Affairs which reports directly to the Deputy Commissioner for Public Health Services. The Center for Consumer and External Affairs provides centralized support to the DSHS Advisory Council; maintains stakeholder relations and provides a central location for public input; evaluates and analyzes customer satisfaction; coordinates the referral of inquiries of divisions within the agency and among other health and human services agencies.

Most educational materials for children and women are published or made available in at least English and Spanish, and frequently in other languages based on need and demand. For example, the Genetics and Case Management program provides most of its materials in English and Spanish, and in collaboration with the WIC Program, Newborn Screening staff are provided access to telephone translation services to assist patients speaking languages other than English or Spanish. The Texas Toll-Free 2-1-1 Line is administered by 25 Area Information Centers (AICs) across the state. All of the AICs provide services 24 hours a day, seven days a week in multiple languages. In many cases, there are Spanish speaking operators. For the other languages, the AICs contract with either Tele-Interpreter or the AT&T Language Line. Services are also available through text telephone or TTY for the hearing impaired.

The CSHCN Services Program works proactively to ensure cultural competence. Bilingual (English and Spanish) and bicultural program staff operate a toll-free line for use by persons applying for and/or receiving the program's health care benefits. In addition, Regional case management and eligibility staff are bilingual. Regional offices also use Language Line Services to assist with communication in multiple languages other than English and Spanish. The program's written communications with its clientele are always done in both English and in Spanish, and the program also has many educational materials available in Spanish.

//2007/ The CSHCN SP hired a bilingual publications specialist to assist in translating publications and other written content. Cultural competency online training information was shared with central and regional office staff, contractors, and the Medical Home Workgroup members. //2007//

/2008/ A bilingual publications specialist assists in translating publications and other written content. The CSHCN SP distributed a bilingual booklet, "Emergency and Disaster Planning for CSHCN", to CSHCN SP health care benefits clients to help families plan and be better prepared for an emergency or disaster. A bilingual Emergency Information Form with instructions was included in the October 2006 issue of the CSHCN Newsletter for Families. //2008//

/2009/ The CSHCN SP participated in the DSHS "Ready or Not" interactive educational events held in cities across Texas, providing copies of the bilingual Emergency and Disaster Planning for CSHCN booklet and Emergency Information Form. The booklet was revised to reflect a lower literacy level to ensure easy access and understanding by a broad audience. //2009//

As part of its ongoing efforts, the CSHCN Services Program continues to seek opportunities to include input from statewide and regional groups and committees with family members who are both bicultural and bilingual. The program's service contractors are grassroots organizations serving communities throughout Texas and their leadership and advisory groups reflect the cultural make-up of the populations they serve. In 2005, the program is participating in the Medical Home Learning Collaborative II (MHLC) conducted by the National Initiative for Children's Healthcare Quality (NICHQ). Three medical practice teams participate. One team is located in Harlingen, Texas at Su Clinica Familiar. The Su Clinica team has helped with the Spanish translation of the family surveys used throughout the MHLC (in other states as well as Texas). Data from Su Clinica are helping to inform the MHLC of some of the cultural issues involved in providing medical home services to a largely Hispanic population. The participation of Su Clinica in the MHLC has heightened the awareness of MHLC, in general, to cultural and communication issues.

/2007/ Largely due to the participation of Su Clinica Familiar, the Medical Home Learning Collaborative II included a significantly increased emphasis on cultural competency. The Su Clinica team either provided or reviewed translation of forms and documents and provided valuable feedback to NICHQ regarding cultural factors and their potential influence on data collection and service provision. //2007//

/2008/ Medical Home initiatives include an emphasis on cultural competency. A bilingual survey gathered information from families about their experiences with the doctor or nurse that their child sees the most related to 14 medical home characteristics. //2008//

The state statutes relevant to Title V program authority and how they impact the Title V program are described in Attachment B.

/2008/Note that Attachment B in the FY08 Application provides the overview of legislative actions that impact maternal and child health which were passed during the most recent state legislative session.//2008//

C. Organizational Structure

/2009/ Please refer to Attachment III. C. for the agency organizational charts effective July 2008. //2009//

The Department of State Health Services (DSHS) is the state agency responsible for administration of the Title V Program and is one of four state health and human services (HHS) agencies under the umbrella of the Texas Health and Human Services Commission (HHSC). HB 2641 of the 76th Texas Legislature and HB 2292 of the 79th Texas Legislature enhanced HHSC's operational responsibility for managing and directing the health and human service agencies through greater supervision of each agency commissioner. As a result, the HHSC Executive Commissioner, as the governor's appointee, is authorized to employ the Commissioner of DSHS with the Governor's approval and to supervise and direct the activities of the Commissioner of

DSHS. Further, HHSC has responsibility for coordinating development and submission of joint agency strategic plans and a consolidated budget. HHSC is involved in policy development for all HHS agency programs and, as such, reviews all proposed rules of all human and health agencies and has final authority to adopt rules for each HHS agency. HHSC, as the State Medicaid Agency and CHIP Agency, is the official policy making body for the portions of those programs administered by DSHS. The increased authority and responsibility of HHSC has been instrumental in increasing coordination for planning and implementation and has helped reduce duplication and maximize resources across the health and human service agencies. Organizational charts that include the Governor's Office, HHSC, DSHS, and the Title V program will be available upon request at the time of the Block Grant review.

There have been major changes in key agency personnel and the organizational structure since the passage of HB 2292 of the 79th Texas Legislature in 2003. Personnel changes have focused on leadership positions existing under the new Department of State Health Services structure.

- Mr. Albert Hawkins, HHSC Executive Commissioner, selected Eduardo Sanchez, M.D., as the new Commissioner for the Department of State Health Services effective January 2004. Dr. Sanchez began his tenure as Commissioner of Health in November 2001. Prior to his appointment in 2001, Dr. Sanchez was an Austin family practice physician and health authority for the Austin-Travis County Health and Human Services Department.

//2008/In November of 2006, Dr. Sanchez accepted a position as the Director of the Institute for Health Policy at The University of Texas School of Public Health. David Lakey, M.D., became Commissioner on January 2, 2007. Prior to becoming Commissioner, Dr. Lakey served as an associate professor of medicine, chief of the Division of Clinical Infectious Disease and medical director of the Center for Pulmonary and Infectious Disease Control at the University of Texas Health Center in Tyler. He had been a faculty member there since 1998. He received his medical degree with honors from Indiana University School of Medicine. Dr. Lakey was a resident in internal medicine and pediatric medicine and completed a fellowship in adult and pediatric infectious disease at Vanderbilt University Medical Center in Nashville, Tenn. He is board certified in pediatrics, internal medicine, infectious disease and pediatric infectious disease. New executive positions were filled in early 2007: Ben Delgado as Associate Commissioner; Luanne Southern, MSW, as Deputy Commissioner; and George William Race, M.D., Medical Director for Behavioral Health.//2008//

//2009/ In June 2008, Dr. Race transferred to lead the State Hospitals Section of the Mental Health and Substance Abuse Division. //2009//

-In February 2004, Ms. Machele Pharr was selected as the new Chief Financial Officer for DSHS. Ms. Pharr has held a number of finance and budget positions at several Texas state agencies and came to TDH in 2002 as TDH's Chief Financial Officer.

-In May 2004, Mr. Randy Fritz was selected as DSHS' Chief Operating Officer. Mr. Fritz has an extensive background in health care administration, policy and legislative experience having served as a Project Director for the S-CHIP program in California for Maximus, Inc., Texas Bureau Chief for the CHIP Program, to former Texas Commissioner of Health Archer and various legislative and/or elected roles, including the top elected role in Bastrop County, Texas.

//2008/Mr. Fritz left the position of Chief Operating Officer and in June 2007, Dee Porter took the position. Ms. Porter has an extensive administrative background including 13 years working in the health care industry and 10 years in Oklahoma state government.//2008//

-DSHS Commissioner Sanchez announced on June 2004 the appointment of Dave Wanser, Ph.D., as the DSHS Deputy Commissioner of Behavioral and Community Health. Dr. Wanser served as the Executive Director of the Texas Commission on Alcohol and Drug Abuse (TCADA) and is chair of the statewide Drug Demand Reduction Advisory Committee. Prior to that, he

spent 14 years at the Texas Department of Mental Health and Mental Retardation, where he was director of the NorthSTAR Behavioral Health Program and director of behavioral health services.

Following these appointments, DSHS aligned the common functions of the three agencies (Texas Department of Health, TCADA, and the mental health component of the Texas Department of Mental Health and Mental Retardation) into coordinated program divisions, facilitating an integrated approach to providing services and ensuring that clients can find and access needed services. These functionally focused divisions include: 1) the Division for Mental Health and Substance Abuse Services (MH/SA); 2) the Division for Family and Community Health Services (FCHS); 3) the Division for Prevention and Preparedness Services; and 4) the Division for Regulatory Services. MH/SA and FCHS Divisions report to Dr. Wanser, Deputy Commissioner for Behavioral and Community Health Services.

The Title V program is located in the DSHS Division for FCHS. Ms. Evelyn Delgado became the Assistant Commissioner for FCHS, effective July 2004. Dr. Fouad Berrahou was re-selected through a competitive process as the State Title V Director effective October 2004. Dr. Berrahou served in the same capacity within the legacy TDH for about three years prior to the HB 2292 Consolidation Act. The Division for FCHS is comprised of three sections and two offices under the Assistant Commissioner for FCHS. The sections are: Sections of Community Health Services, Specialized Health Services, and Nutrition Services and the offices are: Offices of Title V & Health Resources Development, and Research & Public Health Assessment. The Division for FCHS has administrative responsibility for most of the DSHS programs and/or funding streams dedicated to women and children's health, including Title V MCH and CSHCN, Medicaid - EPSDT medical and dental, WIC, Family Planning - Titles X, XX, and XIX, and the Breast and Cervical Cancer Control program. As such, the Division is in a position to coordinate and collaborate across programs effectively. It is also important to note that most funding sources included in the Federal-State Block Grant Partnership budget total, such as WIC, Title X family planning, SSDI, and the federal Bureau of Primary Health Care Cooperative Agreement, are administered by the Assistant Commissioner for FCHS.

Most Title V MCH and CSHCN program areas are located in the following organizational structures:

The Title V & Health Resources Development Office includes the general administration of the Block Grant, Women's Health Area (e.g., maternity and perinatal health, breastfeeding, and domestic violence), Children's and Adolescent Health Area (e.g., early childhood, adolescent mental health, teen pregnancy), the Service Delivery Initiative, and the Texas Primary Care Office (TPCO). This offers opportunities to provide a focal point for women and children's matters and policy development, and the coordination and integration of resources of Title V and TPCO (i.e., J-1 visa waiver and the Incubator FQHC Initiative) to improve access to services for low-income families in underserved areas. The Office also funds initiatives and projects across and outside the agency. The State Title V Director has the responsibility of managing the Title V & Health Resources Development Office and reports to the Assistant Commissioner for FCHS.

//2007/ In February 2006, the Offices of Title V & Health Resources Development and Research & Public Health Assessment were merged. This merger consolidated these two offices into the Office of Title V and Family Health Planning. This newly created office includes three administrative units -- the Family Health Research and Program Development Unit, the Health Data and Reporting Unit, and the Texas Primary Care Office. The objective of the reorganization was to (1) improve synergy between research and practice to inform policy development, (2) promote the development of evidence-based programs, and (3) develop best practices leading to an improved understanding and response to the health and health care needs of the Texas women, adolescent, child, and infant population. Attachment D shows Title V funding and resources allocation within DSHS. //2007//

The Section for Specialized Health Services (SHS) is made up of two units: 1) the Purchased Health Services Unit includes CSHCN, Kidney Health Care, Anatomical Gift Educational

Program, Children's Heart Outreach Program, and Hemophilia Assistance Program; and 2) the Health Screening and Case Management Unit includes Newborn Screening and Case Management, Oral Health, Texas Health Steps (formerly EPSDT), Case Management for Children and Pregnant Women, Newborn Hearing Screening, Program for Amplification of Children of Texas, School Vision and Hearing Screening, and Spinal Screening. Ms. Jann-Melton Kissel is the Director of SHS and Dr. Lesa Walker is the Title V CSHCN Director. /2007/ An integrated organizational structure for the Purchased Health Services Unit was established January 1, 2006. Prior to January 1, 2006, the Purchased Health Services Unit existed as Adult Purchased Health Services, which included kidney health care, and Child Purchased Health Services, which included children with special health care needs. The integration of these two units allowed for enhanced transition to safety net services to eligible clients, enhanced sharing of information regarding program services, and potential cost savings resulting from efficiencies gained through integration. //2007//

The Section for Community Health Services (CHS) is comprised of two units: 1) the Preventive and Primary Care Unit (PPCU) and 2) the Performance Management Unit (PMU). CHS provides oversight for contracted community health services activities for Titles V, X, XV (Breast and Cervical Cancer), XX, Primary Health Care, Indigent Health Care, Epilepsy, and Title XIX Family Planning. The PPCU is responsible for developing policies and procedures for contracted community health services activities. The PMU develops guidelines, processes, and instruments for contract management and quality assurance for CHS programs and WIC services.

The Research and Public Health Assessment (R&PHA) Office provides the MCH epidemiology support for all Title V program areas and is responsible for SSDI . Dr Linda Bultman manages the R&PHA Office. /2007/ Under the newly created Office of Title V and Family Health Planning, the MCH epidemiologic support is now provided by the Family Health Research and Program Development Unit. This unit includes 6 full time researchers and 5 subject matter experts in areas of women and children's health who support the needs of FCHS programs while simultaneously pursuing independent research projects. The Family Health Research and Program Development Unit has responsibility for the State System Development Initiative (SSDI) grant. The Health Data and Reporting Unit maintains program data for several FCHS programs, including Title V, WIC, and THSteps. The Health Data and Reporting Unit is instrumental in the completion of service reports and program monitoring activities.

Originally in the consolidation of health and human service agencies and the reorganization of the state health department, the Regional and Local Services Section was placed in the Division of Preparation and Preparedness (P&P). The Section was responsible for facilitating operations between the DSHS Central Office and the 11 Health Services Regions (HSRs), and for ensuring that the regions had the resources they needed to work effectively at the local level. It became clear, however, that positioning this section within P&P was not effective, because the HSRs represent all DSHS programs at the regional level, not just those associated with that Division. Further, an outcome of the Regional Review Project conducted by DSHS Internal Audit in 2005 showed that both Central Office and the regions felt that communication between the two entities needed improvement. After DSHS held a series of stakeholder meetings in February 2006 regarding the state role in local public health, an internal workgroup group was assembled to examine the agency's role in assuring the essential public health standards. Out of this came the decision that the Regional and Local Services Section would become the Division of Regional and Local Health Services and report directly to the Commissioner of Health. The Texas Title V Director is a member of the Regional and Local Health Services (RLHS) Launch Project Steering Committee which was established to provide guidance and oversee the launching of RLHS, including the development of a Business Plan to include the vision and mission of the new Division; an organizational structure and staffing plan; goals, objectives and an action plan for FY07; an FY07 budget; and a stakeholder relations/communication plan. It is anticipated that elevating Regional and Local Services to the Division level will benefit Title V by providing a sound foundation for building and enhancing local infrastructure. The existence of functioning, well-supported regional offices ensures local Title V representation as well as a direct connection

to Title V contractors. Regional staff often serves in multiple functions, meaning that they have the opportunity to network and make relevant connections with other programs that can contribute to improving maternal and child health and to enhancing the local public health infrastructure.

An attachment is included in this section.

D. Other MCH Capacity

/2007/ Attachment E shows the personnel funded by the Title V program in the DSHS Central Office (CO) in Austin and the 11 HSRs. A net decrease of 28 FTEs occurred when comparing FY06 to FY05. This decrease is due to reassignment from HSRs to the Central Office of 18 staff who monitor Title V-funded programs and the consolidation of functions for Texas health and human agencies as mandated by the passage of HB 2292, 78th Legislature, resulting in 10 fewer FTEs.//2007//

/2008/Attachment III.D. includes updated information on personnel. From FY06, there was a net decrease of 13 FTEs, 7 in CO and 6 in HSRs, due to streamlining efforts in the agency.//2008//

/2009/ Attachment III.D. includes the total number of positions funded by Title V. In FY07, there was a net decrease of 5 full time equivalent positions, 3.5 in CO and 1.5 in the HSRs. There was an increase of approximately 14 FTEs in the Human Service Specialists classification to address greater efforts in case management, while a similar number of Administrative Assistant positions were reduced. //2009//

Title V program areas are primarily located in the Family and Community Health Services (FCHS) Division, which consists of two offices (Title V & Health Resources Development, and Research & Public Health Assessment) and three sections (Community Health Services, Specialized Health Services, and Nutrition Services). Although, each Title V professional staff member uses planning to some extent to influence the course of his or her daily activities and responsibilities, directors and managers of the offices and sections/units are in the best position to know what their program areas are currently facing (or will face in the future), and in turn, to make strategic decisions and policy in light of current and future effects. Directors and managers may delegate the decision-making function to selected program specialists who, on a routine basis, play the role of catalysts in or facilitators of the planning process. It is important to note that some DSHS program specialist job descriptions are similar to those of conventional planners.

The Research & Public Health Assessment (R&PHA) Office provides the MCH epidemiology support to the FCHS Division. The primary services include expert statistical analysis, data management and program reporting, geographical/spatial analysis, Title V performance measures, research design and consultation, epidemiological analysis and literature reviews, case finding and active surveillance via PRAMS. R&PHA is also responsible for the State Systems Development Initiative (SSDI) and coordinates a blending of activities with PRAMS to assure existing statewide surveillance.

/2007/ R&PHA and the Title V and Health Resources Development Office have merged to establish the Office of Title V and Family Health Planning to improve synergy between researchers/statisticians and Title V subject matter experts. Under the oversight of the Title V MCH Director, the new office includes 1) the Family Health Research and Program Development Unit, responsible for expert statistical analysis, geographical/spatial analysis, research design and consultation, epidemiological analysis, literature reviews, and the SSDI Grant; and 2) the Health Data Assessment & Reporting Unit, responsible for data management, program reporting, and the operations of PRAMS.

Through the new structure, Title V has initiated meetings with university partners to explore possible collaborative efforts to develop or test best practices and enhance surveillance activities.

Title V seeks to formalize relationships with university partners to continue to strengthen the evidence-base for all programmatic activities and increase the MCH knowledge base in Texas.
//2007//

The CSHCN Services Program (CSHCN SP) has not hired parents of CSHCN to serve on staff specifically in their parental capacity. However, the program does have certain staff who happen to be parents of CSHCN. These staff members participate in the program decision-making process and some choose to offer their valuable insights and feedback to the program on an ongoing basis.

***/2009/ A CSHCN SP staff person is the Texas Family Delegate to AMCHP and was accepted as an AMCHP Family Mentor and Family and Youth Leadership Committee member.
//2009//***

Below are summaries of the qualifications of senior level employees:

Dave Wanser, Ph.D. is the Deputy Commissioner for Behavioral and Community Health at DSHS, the consolidated department for mental health, substance abuse and physical health. Dr. Wanser's responsibilities include administration of contracted services for a wide range of mental health, substance abuse, primary and preventive care and nutrition services and oversight of the state mental health and public health facilities.

Prior to his appointment as Deputy Commissioner, he served as Executive Director of the Texas Commission on Alcohol and Drug Abuse (TCADA) for three years. TCADA purchases evidence-based prevention and treatment services, and is a national leader in the use of web-based data infrastructure for behavioral health services. As TCADA Executive Director, he chaired the statewide Drug Demand Reduction Advisory Committee comprised of 19 state agencies.

During his 15-year tenure at the Texas Department of MHMR, Dr. Wanser served as the Director of Behavioral Health Services and Director of NorthSTAR Behavioral Health Program, a multi-agency capitated managed care program in north Texas. NorthSTAR was named a semi-finalist in the 2001 and 2002 Innovations in American Government competition sponsored by Harvard University.

In addition, Dr. Wanser has been a consultant to the Center for Mental Health Services Mental Health Performance Partnership Grant Program since 1994. He is first vice-president of the Board of Directors of the National Association of State Substance Abuse Directors and was previously the chairperson of the Adult Services Division of the National Association of State Mental Health Program Directors. He has a Ph.D. in psychology from the University of Oklahoma.

/2008/In March 2007, after serving as a deputy commissioner of DSHS since 2004, he left to explore other opportunities within the Health and Human Services enterprise agencies. In 2007, DSHS leadership established the position of Medical Director for Behavioral Health that will work with the new Deputy Commissioner to strengthen efforts to integrate programs across the agency.//2008//

Ms. Evelyn Delgado is the Assistant Commissioner of FCHS at DSHS. Ms. Delgado is responsible for programs improving the health of all Texans, focusing on communities, families, women and children through preventive and direct health services. These programs provide direct health service to over 1.5 million Texans per month.

Ms. Delgado has an extensive background in finance and management in both the private and public sectors. She has served as the Assistant Deputy Commissioner of Long Term Care Regulatory, Assistant Regional Administrator, and in other professional capacities during her career with the Texas Department of Human Services. Ms. Delgado has actively served in United Way organizations that serve families, children and the elderly.

Ms. Delgado's educational background includes a business administration degree from Trinity University in San Antonio. She is a graduate of the LBJ School of Government Governor's Executive Training program.

Fouad Berrahou, Ph.D., was named State Title V Director effective July 2002. Dr. Berrahou is the Director of the Title V and Resources Development Office and primarily responsible for coordinating the management and administration of the Texas Title V program and reports directly to the Assistant Commissioner for FCHS Division. He also oversees the Primary Care Office activities, such as the Incubator FQHC Grants Initiative, which provides financial support and technical assistance to interested local health care organizations to becoming an FQHC. Dr. Berrahou has been with the Texas Department of Health (TDH) and then DSHS for 12 years. During this time, he worked in a variety of capacities as a health planner for the former Bureau of Women and Children and Assistant to the State Title V Director within the former Associateship for Family Health.

Dr. Berrahou graduated from the "Universite' Des Sciences and Technologies" (Oran, Algeria) with a bachelor's degree in Architecture, specializing in health care facility design; he received his master degree from the College of Architecture of the University of Houston; and completed his Ph.D. in health planning at Texas A&M University in 1993.

/2007/ Brian Castrucci joined DSHS in April 2006 as the Director of the Family Health Research and Program Development Unit. He came from the Philadelphia Department of Public Health where he was the Assistant Division Director for Policy, Program, and Planning. He has published on a variety of topics including breastfeeding initiation, smoking and other substance use, and HIV/AIDS policy. He received a bachelor's degree in political science from North Carolina State University and a Master of Sociomedical Sciences Degree from Columbia University.//2007//

/2008/Rom Haghghi, PhD, is Director of Health Data Assessment and Reporting Unit. He has over 24 years of experience in data analysis, program evaluation, policy analysis and grants. He received his B.A. and M.A. in Political Science and Ph.D. in Criminology from Sam Houston State University.//2008//

/2009/ In March 2008, Mr. Haghghi resigned his position with the agency. //2009//

Ms. Margaret Mendez serves as the Director of the Community Health Services Section, which was established in September 2004. The Section provides oversight for contracted community health services, including Breast and Cervical Cancer Control program, Family Planning programs (Titles V, X, XX and XIX), Primary Health Care, Epilepsy program, and County Indigent Health program. From 1999-2004, Ms. Mendez served as the Chief of the Bureau of Women's Health. From 1991 until 1999, Ms. Mendez served as the Director for the Breast and Cervical Cancer Control Program with TDH. She served as the director for a multi-purpose community health care center responsible for providing acute, preventive, and chronic care for all age groups in addition to providing support services for families. She held several positions as a policy analyst and health planner at TDH, a local health department, and the Governor's Office. Ms. Mendez received a bachelor's degree from the University of Texas at Austin and a Master of Public Affairs Degree from the LBJ School of Public Affairs at Austin.

/2009/ Ms. Mendez left the position retired in March 2008 and Mr. Patrick Gillies was selected to lead the Community Health Services Section in the spring of 2008. Mr. Gillies has a Masters in Public Administration with a focus on health policy from Texas Tech University. His experience includes directing state and federally funded behavioral health programs and working with communities and stakeholders. //2009//

/2008/Lauri Kalanges, MD, MPH, is the Medical Director, Preventive and Primary Care Unit. Her

clinical education and experience is in the areas of surgery and public health with a focus on women's health issues. She received her medical degree from University of Nevada School of Medicine. Her surgery residency and fellowship were completed at the Ohio State University; and her MPH was earned at the University of Massachusetts at Amherst.//2008//

Lesia R. Walker, M.D., M.P.H., is the Texas Title V CSHCN Director. At present, she is also Medical Director of the CSHCN Services Program and Group Manager for the CSHCN and Title V Group in the Purchased Health Services Unit of DSHS. She oversees the Title V CSHCN activities, initiatives, and systems development for Texas and is involved in policy decisions and Rule-setting for the CSHCN Services Program.

Dr. Walker has been employed at DSHS (TDH prior to September 2004) for 19 years. From December 2002 until September 2004, she served as the Medical Director/ Director of the Public Health Policy Unit of the CSHCN Division in the Bureau of Children's Health and the Texas Title V CSHCN Director. From June 2002 through November 2002 she served as the Acting Director of the Children with Special Health Care Needs (CSHCN) Division. From September 1996 until June 2002, she served as the Director of Systems Development in the CSHCN Division. From May 1994 to September 1996, she was the Director of Special Initiatives in the Children's Health Division, focusing on special initiatives pertaining to CSHCN. From October 1993 to May 1994 she was the Director of the Children's Health Division, which included the Chronically Ill and Disabled Children's Services Program (CIDC; currently the CSHCN Program) as well as EPSDT (now Texas Health Steps). From April 1993 to October 1993 she served as the Acting Bureau Chief for the CIDC Bureau. From May 1986 to April 1993 she was the Medical Director for the CIDC Bureau.

Her educational background is as follows: B.A. in Biology, 1976, from the University of Texas at Austin, Texas; M.D., 1980, from Baylor College of Medicine in Houston, Texas; M.P.H., 1982, from the University of Texas School of Public Health in Houston, Texas; Pediatric internship (Baylor College of Medicine in Houston, Texas and the Medical College of Ohio in Toledo, Ohio); Preventive Medicine/ Public Health Residency at the University of Michigan School of Public Health in Ann Arbor, Michigan; Board Certification in General Preventive Medicine/ Public Health by the American Board of Preventive Medicine, January 31, 1989.

Ms. L. Jann Melton-Kissel, RN, MBA, serves as Director, Specialized Health Services (SHS) Section, effective September 2004. The SHS Section is comprised of two units: Purchased Health Services Unit which includes CSHCN, Kidney Health Care, Anatomical Gift Educational Program, Children's Heart Outreach Program, and Hemophilia Assistance Program; and Health Screening and Case Management Unit which includes Newborn Screening and Case Management, Oral Health, Texas Health Steps (formerly EPSDT), Case Management for Children and Pregnant Women, Newborn Hearing Screening, Program for Amplification of Children of Texas, School Vision and Hearing Screening, and Spinal Screening. As Section Director, Ms. Melton-Kissel has the responsibility for directing, planning, implementing, and evaluating health services for children in Texas. The Section continues its focus on increasing service integration, and is working to assure that systems are accessible for clients, community members, and providers.

Before coming to the former TDH, Ms. Melton-Kissel worked in a large metropolitan teaching hospital in the field of obstetrical nursing. She began employment with the former TDH in 1986, working in the Health Care Facility Regulatory Program. Over the years, Ms. Melton-Kissel has held multiple positions at TDH at the Division, Bureau, and Associateship levels gaining experience in budget and management.

/2007/ Mike Montgomery is the Director of the Nutrition Services Section. He has more than 30 years experience with WIC, having served across the spectrum of management and administration in positions at the federal, state, and local level. He came to the Department of

State Health Services (DSHS) in 1996 to serve as the leader of the Texas WIC project development team for the Electronic Benefits Transfer (EBT) project. //2007//
An attachment is included in this section.

E. State Agency Coordination

Due to its role in infrastructure building and due to the nature of services it provides and the various populations it serves, the Texas Title V program has multiple opportunities to collaborate with federal, state and community partners. On the federal level, Title V works with the Department of Health and Human Services (DHHS) Region VI Office of Women's Health (OWH) Alliance to prioritize, develop and implement women's health efforts in the region. Alliance meetings take place regularly throughout the year. Alliance members, who include women's health representatives from each of the states in the Region, have developed a five-year strategic plan to promote women's health throughout the Region, linking activities to federal and state initiatives and programs. Current activities include producing state summits on women's health, meeting with representatives from DHHS Region 1 OWH Alliance to share experiences and best practices experiences and working to develop a network of local women's health networks within Texas. Alliance meetings also serve as a format to provide members with state of the art information on health issues impacting women and on federal efforts to improve the status of women's health throughout the lifespan. The Title V Perinatal Health Coordinator serves on the Alliance for Region VI.

Another collaborative effort with HRSA resulted in the review of the Texas' Newborn Screening program. The Department of State Health Services (DSHS) partnered with the National Newborn Screening Genetics Resource Center (NNSGRC) to conduct the review, which included stakeholder meetings in Austin, Dallas, San Antonio and Houston. NNSGRC is under contract with HRSA to provide technical assistance to states and territories. NNSGRC convened a review team of nine professionals from across the country that included physicians, follow-up staff, laboratory staff, CDC and HRSA representatives. The process involved an onsite review of the program, evaluation of program materials, interviews with program staff, discussions with stakeholders and responses to specific questions posed by the program. Texas is now in the process of reviewing the draft report and formulating recommendations for program enhancement.

Title V collaborates both with agencies under the auspices of the Health and Human Services Commission (HHSC), including the Department of Family and Protective Services; the Department of Aging and Disability Services; and the Department of Assistive and Rehabilitative Services; and with agencies outside of this area, such as the Texas Education Agency and the Texas Workforce Commission.

HHSC administers the Texas Medicaid program and Children's Health Insurance Program (CHIP). A woman is eligible for Medicaid if she meets the requirements for TANF. If a pregnant woman is at or below 185% federal poverty level, she receives Medicaid benefits until 60 days postpartum. HHSC is also responsible for CHIP, which serves children ages 0-19 from low-income families. Medicaid, CHIP and Title V are natural partners that work together effectively to meet the needs of women, children and families. Title V is considered a program of last resort, primarily designed to serve individuals who do not meet the Medicaid or CHIP eligibility requirements. Through an integrated screening process, individuals are referred to the appropriate program based on eligibility. Another link between the programs is the reimbursement rate. Title V does not participate in setting the rates, but uses them in reimbursing fee-for-service contractors.

A potential change in CHIP resulting from the 79th Texas Legislature will impact Title V. Pending approval by the federal government, CHIP coverage will expand to cover eligible children during the prenatal period. This expansion will provide prenatal care to women not eligible for Medicaid due to their immigration or financial status. If approved, a large percentage of the women

currently receiving prenatal care under Title V will receive care through CHIP, freeing up Title V funds for other areas.

/2008/Effective 1/2/07, the CHIP expanded to provide prenatal care through managed care organizations. Title V and HHSC staff worked together to encourage Title V providers of opportunities to become CHIP providers to deliver prenatal care.//2008//

/2009/ Title V and HHSC continued efforts to ensure that changes related to the new CHIP perinatal benefits did not interrupt services to pregnant women. From the initial 1,129 women enrolled in January 2007 to the most recent monthly enrollment figure of 32,061 in May 2008, CHIP perinatal benefits have clearly become an important resource for women. Title V continues to provide the necessary gap filling services that are required to promote access to prenatal care during the CHIP eligibility determination process. //2009//

The Texas Health Steps (THSteps) program (federally known as EPSDT) has regionally- based state and contracted FTEs, who collaborate with many partners to promote THSteps services, activities, and benefits. The outreach and informing contractor is obligated to meet with community-based organizations, such as Early Childhood Intervention (ECI), WIC, Head Start, Independent School Districts (ISD), Migrant Coalitions and others in an effort to promote the understanding of preventive health care and the importance of services being accessed. In 2006, a renewed focus will be on coordinating efforts with the Department of Family and Protective Services (DFPS) to ensure that children who are involved in the protective services arena are also accessing needed services. Additionally, THSteps will continue to enhance outreach to Title V-funded clinics providing preventive health services.

/2008/THSteps and associated programs at the DSHS and HHSC have collaborated to develop a comprehensive online provider education campaign. The primary goals of the campaign include: Informing and educating providers about THSteps services and Medicaid services for children from birth to 20 years of age, the importance of providing a comprehensive check-up that includes all THSteps-required components, laboratory tests, and immunizations. (<http://txhealthsteps.com>) //2008//

HHSC also administers Food Stamps and TANF, Child and Adult Nutrition Programs, Nutrition Education and Training, Commodity Distribution Programs and the Family Violence Program. The Family Violence Program goal is to promote self-sufficiency, safety, and long-term independence from family violence for adult victims and their children. The strategy is to provide emergency shelter and support services to victims of family violence and their children, educate the public, and provide training and prevention support to various agencies. Title V is working to increase screening for domestic violence at its Title V-funded clinics and serves as a referral source for these services. The Title V program has been working with HHSC to develop a comprehensive plan to prevent domestic violence in Texas. In 2004, HHSC directed DSHS to present the document, "A Strategic Plan to Prevent Violence Against Women" to appropriate state agency leaders for review and to solicit recommendations regarding approval of the plan. Recommendations were received from the "Family Violence Program" at HHSC; the Department of Family and Protective Services; the Department of Aging and Disability Services; the Department of Assistive and Rehabilitative Services; and the Office of the Attorney General. The plan was approved in December 2004. DSHS and Title V program will coordinate with each of these state agencies and with the Interpersonal Violence Prevention Collaborative in the implementation of the plan.

/2008/In FY08, SSDI will work to gather and analyze data from agencies responsible for child protection, juvenile justice, and public safety to obtain a more detailed understanding of the needs and challenges of the MCH population.//2008//

Title V also collaborates with the Community Resource Coordination Groups (CRCGs) of HHSC. CRCGs are community-based interagency teams comprised of public and private providers who

work with family members to develop individual service plans for children and adolescents whose needs require interagency cooperation. A bill passed by the 77th Texas Legislature called for the development of a joint Memorandum of Understanding (MOU) between health and human services agencies, related state agencies and state-level partners to promote a statewide system of local-level interagency CRCGs to coordinate services for children and youth who require services from more than one agency. The MOU is reviewed and updated on a regular basis. Regional Title V social workers serve on all local CRCGs and central office staff are represented on the state advisory committee. Currently, there are approximately 150 CRCGs in Texas.

Two other partnerships that fall under HHSC are the Office of Early Childhood Coordination (OECC) and the State Early Childhood Comprehensive Systems (SECCS) Grant. The OECC is responsible for promoting community support for parents of all children younger than six years of age through an integrated state and local-level decision-making process, and for providing for the seamless delivery of health and human services to all children younger than six years of age to ensure that all children are prepared to succeed in school. Title V staff work closely with the OECC to help achieve its mission and objectives and to implement the SECCS Grant which seeks to develop a comprehensive, coordinated early childhood service system through the development of a comprehensive state plan.

//2009/ In FY08, Title V Leadership, including the Assistant Commissioner for Family and Community Health Services Division and the Title V MCH and CSHCN Directors continued to provide input to the ECCS steering committee. The implementation teams have focused on the four areas of the project: access to insurance and medical home; social emotional development and mental health; early care and education; and parent education and family support. .In addition, DSHS staff in CSHCN SP and the Title V Office continued their efforts to support the interagency efforts of the ECCS project, known as Raising Texas. Collaborative efforts of Raising Texas and Title V staff have included examination of child care health consultation and applying for Substance Abuse and Mental Health Services Administration Project LAUNCH funding. //2009//

Title V staff have collaborated for a number of years with the federal Special Supplemental Nutrition Program for Women, Infants and Children (WIC), administered by DSHS, on breastfeeding promotion and other projects designed to enhance the health of their shared populations, such as smoking cessation and promotion of healthy nutrition and physical activity.

Under the oversight of the Title V program, the Teen Pregnancy Prevention Workgroup (TPPW) works closely with mental health and substance abuse programs and the WIC program within the agency. TPPW also coordinates with the Texas Office of the Attorney General, specifically with the "Fragile Families" Program and the "Fatherhood Initiative."

//2009/ Based on recommendations and learning from the Hispanic Teen Pregnancy Summit held in October 2007, Title V identified members for a steering committee that could provide input into the plans to address adolescent pregnancy in Texas. This steering committee had its inaugural meeting on May 30, 2008, and provided input to be used in a collaborative effort with the University of Texas at Austin to conduct focus groups and develop and implement a quantitative survey to identify options for future activities. //2009//

Title V staff have working relationships with the Texas Medical Association (TMA) as well as the professional organizations for pediatricians, family practice doctors, obstetrician-gynecologists, certified nurse midwives and direct entry midwives. Through these relationships, information, knowledge and resources are shared and entities work to further joint projects and common goals. Title V staff communicate regularly with TMA staff on events and activities at both organizations. TMA is represented on maternal and child workgroups at DSHS, including the PRAMS Advisory Committee and the Perinatal Depression Provider Partnership coordinated by Title V program. Title V staff also provide information for the TMA Committee on Maternal and

Perinatal Health meetings. The agencies have partnered on activities, such as the development of a letter from physicians to employers regarding the benefits of supporting their employees who desire to pump breast milk during the workday in order to maintain breastfeeding.

Texas has six HRSA-funded Healthy Start projects, located in Fort Worth, Dallas, Houston, San Antonio, Brownsville and Laredo. These community-based maternal and child health programs work to reduce infant mortality, low birth weight and racial disparities in perinatal outcomes and also screen and refer for perinatal depression. Individually, Healthy Start Projects initiate activities to promote breastfeeding, immunization, and maintaining a healthy weight. The projects have joined together to form the Texas Healthy Start Alliance (TxHSA), which provides a forum for networking, resource sharing and collaboration for the projects and serves as a link to the National Healthy Start Association. TxHSA and Title V work together on joint projects, such as the annual Texas and DHHS Region VI conferences and the perinatal depression provider partnership.

//2009/ In January 2008, the Women's and Perinatal Health Coordinator (WPHC) attended the regional Healthy Start conference in which Title V provided sponsorship. She is in the process of visiting all of the six Texas sites, working with the Healthy Start Alliance to share PPOR data and analysis, and is serving on the conference planning committee for the FY09 conference. //2009//

The Texas March of Dimes (MOD) funds short-term projects that seek to improve perinatal outcomes; serves as the state-level interface with the national Prematurity Campaign and seeks to connect resources, develops state-level activities, and raises awareness among state and local government and business leaders and the public regarding prematurity. The MOD's commitment to improving prenatal outcomes and reducing prematurity aligns with the goals of the Title V program. MOD is represented on various DSHS maternal and child health workgroups, such as the perinatal depression provider partnership and the PRAMS advisory committee. Title V staff serve on the MOD statewide program services committee and the Prematurity Campaign Committee. DSHS and MOD are also partnering on publications, folic acid promotion and other projects to prevent prematurity and low birth weight rates and reduce infant mortality.

//2007/To support evidence-based program planning, Title V provided MOD with analyses of low birth weight in the general population and population subgroups using PRAMS data. The analyses provided will help MOD develop programs to address prematurity and infant mortality in African American communities. //2007//

Texas Perinatal Association (TPA) provides perinatal education for doctors, nurses, administrators and other personnel in the rural communities in Texas, primarily through conferences and workshops. The TPA is a critical resource for conveying information to providers about Texas Title V activities. Regional Title V staff work with TPA to produce two regional conferences a year to educate providers on issues relevant to improving perinatal outcomes in Texas.

Title V coordinates and funds adolescent health activities in conjunction with the Texas Education Agency (TEA) Regional Service Centers and the Texas Council Center through the Texas School Health Network. The network collaborates with school districts to plan and implement school health programming with the goal that all students receive a program of physical and health education, appropriate health services, and a nurturing environment. Regional School Health Specialists are stationed in each Regional Education Service Center and are contacts for DSHS programs, such as abstinence education and injury prevention. TEA regularly provides updates to statewide partners on grant funding opportunities, education policy changes, and other updates related to adolescent health. Title V also coordinates with Baylor College of Medicine, which is a recipient of the Federal Maternal Child Health Leadership in Adolescent Health Education grant. Baylor provides training and technical assistance on adolescent issues to the DSHS Texas Health Steps Program, the state program for EPSDT.

//2007/Title V is expanding epidemiologic efforts in obesity research through collaboration with state universities. A joint project with Texas Tech University will investigate the association of socioeconomic and other factors with obesity. Title V will collaborate with the University of Texas Health Sciences Center at Houston to resume and expand the Sports, Physical Activity and Nutrition (SPAN) survey, administered to 4th, 8th, and 11th graders in even years. Expansion of representativeness of the sample, inclusion of rural and border schools and a linked parent questionnaire will be explored.

Title V has expanded its relationship with the Texas Office of the Attorney General (OAG), Crime Victim Services Division by providing expertise to support OAG activities for a CDC-funded cooperative agreement to develop a sexual violence prevention and education program.//2007//

CSHSN

The creation of the Department of State Health Services (DSHS) on September 1, 2004 provides new opportunities for coordination within DSHS and with other state agencies. The newly formed DSHS includes substance abuse and mental health services as well as the programs historically associated with the legacy Texas Department of Health. Thus, the CSHCN SP will have increased opportunities to coordinate services with substance abuse and mental health services programs. Ongoing partnerships with other state and federal agencies and partners play an important role in CSHCN SP and assist in the program's ability to meet the needs of the CSHCN population. Some of these partnerships are detailed below.

CSHCN SP will continue to provide leadership in coordinating development and promotion of medical homes through the Medical Home Workgroup (MHWG) and the Medical Home Learning Collaborative (MHLC). The MHWG includes representatives from the Health and Human Services Commission (HHSC), the Department of Aging and Disability Services (DADS), the Department of Family and Protective Services (DFPS), and the Department of Assistive and Rehabilitative Services (DARS), as well as, family members, advocates, and private providers. The MHWG meets quarterly to report on efforts of agencies and groups and to continue work on the strategic plan to educate providers and families and promote the development of medical homes. The CSHCN SP coordinates Texas' participation in the MHLC. The HHSC State Medicaid and CHIP Director is part of the state team. The MHLC is a HRSA funded opportunity to work with local medical practices and other states to demonstrate and learn about medical homes and their efficacy.

//2007/ New members to the Medical Home Workgroup (MHWG) in FY06 included family practice physicians, representatives of the Texas Association of Community Health Centers, Texas Health Steps, and Newborn Hearing Screening staff. Participation has strengthened the workgroup's efforts related to the Medical Home Strategic Plan. Increased collaboration between the CSHCN SP and HHSC Medicaid Program resulted in health care benefits policy development, proposed medical home inservice training, and increased awareness among Medicaid/CHIP managed care organization medical directors. The Medical Home Strategic Plan has been incorporated into the Texas Early Childhood Comprehensive Systems plan. This plan is addressed in the HHSC strategic plan. //2007//

Collaboration with the state Medicaid program and with federal Title XIX occurs extensively through the Benefits Management Workgroup (BMW), a Medicaid and CSHCN SP policy development and coordination workgroup led by HHSC and the claims contractor for Medicaid and CSHCN SP. CSHCN SP staff participates in the leadership of the BMW. CSHCN SP collaborates with the Children's Health Insurance program and federal Title XXI by providing "wrap around" services (e.g. travel, case management, durable medical equipment, etc.) to children on CHIP who may need them.

CSHCN SP will collaborate with the Texas Department of Insurance, HHSC, the Texas Council

for Developmental Disabilities and others to help increase the effectiveness of private insurance for CSHCN. Among efforts being explored by HHSC is the development of a program to empower families to negotiate with their private health insurance providers.

CSHCN SP staff serves on the HHSC Consumer Directed Services Advisory Committee which helps develop mechanisms for greater consumer direction in Medicaid state plan programs and waivers.

CSHCN SP staff serve on interagency initiatives involving many agencies working to improve the overall service delivery system for CSHCN and others. A CSHCN SP staff member is appointed by the Governor to the Early Childhood Intervention (Part C of IDEA) Advisory Committee to address the service needs of children with developmental delay from birth to age 3 and their families. A CSHCN SP staff member serves as the DSHS appointee to the Texas Council for Developmental Disabilities, an agency funded under the Developmental Disabilities Act to address systems change, capacity building, and advocacy to promote the independence, productivity, and inclusion of Texans with developmental disabilities. A CSHCN SP staff member serves on the Community Resource Coordination Groups (CRCG) interagency team. The team helped develop a revised memorandum of understanding to reflect the changed structure of the health and human services system in Texas and update the interagency effort to assist children and adults with complex needs. Regional staff continue to serve on interagency CRCGs throughout Texas. CSHCN SP staff serve on the Texas Integrated Funding Initiative, a demonstration project blending funding to more effectively and efficiently serve children with severe emotional disturbances.

/2008/ The CRCG state work group recently served as a means of interagency planning and information exchange to facilitate legislatively-mandated discharge of a large number of youth from incarceration at Texas Youth Commission facilities.//2008//

/2009/ The CSHCN SP is tracking and will collaborate with HHSC Medicaid Reform efforts (SB10 - Texas 80th Legislature) in planning and developing a tailored benefit package for CSHCN. CSHCN SP staff were appointed to the Consumer Direction Workgroup and the HB 1230 Workgroup (enacted by the Texas 80th Legislature to improve employment opportunities and outcomes for youth with disabilities). //2009//

CSHCN SP staff serve on interagency committees addressing specific conditions such as asthma, oral health, traumatic brain injury, and trauma and EMS.

/2007/ CSHCN staff presented information on the American Association of Pediatricians/American College of Emergency Physicians Emergency Information Form (EIF) to the Governor's EMS and Trauma Advisory Council (GETAC). The Committee posted the information on its website to disseminate statewide.//2007//

A CSHCN SP staff member is the DSHS agency representative on the Interagency Council on Autism and Pervasive Developmental Disorders, established by legislation in 1987. The Council is composed of seven family members, appointed by the governor, and representatives from five state agencies, appointed by the commissioners of the respective agencies. The Council develops a state plan that identifies and articulates the needs of individuals with autism and other PDDs, makes recommendations to state agencies providing services, and advises the Texas Legislature about legislation needed to develop and maintain quality intervention and treatment services.

CSHCN SP staff serve on the Children's Policy Council (CPC), a council of family members with many agencies represented. The CPC was established by legislation to recommend policies and practices to agency and elected leaders to improve the service delivery system for children with disabilities and special health care needs. The CPC submits an extensive status report and

recommendations to the Texas Legislature every two years.

CSHCN SP leads a DSHS Transition Workgroup that is expected to become multi-agency over time. Recently proposed legislation would require DSHS to collaborate with DARS and the Texas Education Agency to develop a memorandum of understanding to coordinate efforts to assist youth with disabilities in their transition to adulthood. This legislation is not signed and its outcome depends on the results of the current Special Legislative Session. //2007/ No action was taken by the 79th Texas Legislature on a requirement for an MOU. //2007//

//2008/ The DSHS Transition Workgroup developed and implemented an online transition training program for case managers. DSHS Title V staff will represent DSHS on the interagency workgroup convened by the Department of Assistive and Rehabilitative Services (DARS) to improve transition for students enrolled in special education. CSHCN SP staff was unable to recruit enough adults or youth or gain statewide momentum to develop a mentoring initiative. A few local groups exist. CSHCN SP staff are analyzing the feasibility of continuing this activity.

Members of the DSHS Transition Workgroup provided leadership for a Teen Transition Expo one-day event in conjunction with the Third Texas Parent to Parent Annual Conference, and this event may lead to greater CSHCN SP participation by teens or young adults with disabilities. By action of the 80th Texas Legislature (2007), the DARS transition counselors will receive specialized transition training and a multi-agency transition task force will be created. CSHCN SP staff anticipates being involved in this effort and in increased interaction with transition specialists at Texas Education Agency Education Service Centers to promote inclusion of important health care concerns in rehabilitation and education transition services.//2008//

//2009/ CSHCN SP staff planned for the Second Teen Transition Expo to be held in June 2008. CSHCN SP staff participated in HHSC's Transition and Supported Employment Workgroup and developed a curriculum and taught clients of centers for independent living regarding health care transition issues. //2009//

In addition, family members of CSHCN and providers are active in state policy and systems development through their participation in the Regional Advisory Committees for Medicaid Managed Care. Certain of these Regional Advisory Committees have formally established a subcommittee to focus on CSHCN.

The Title V CSHCN five-year needs assessment and annual planning process involved multiple stakeholders, including representatives of the health and human services and education state agencies. The needs assessments and strategic plans of the groups named above were considered and used as key indicators of stakeholder input. Through its interagency coordination efforts, the CSHCN SP has been effective in making other agencies aware of the CSHCN Title V performance measures, and, in many cases, uniting support for working toward achieving those measures.

F. Health Systems Capacity Indicators

Introduction

The Health Status Capacity Indicators (HSCIs) for Texas identify areas of great improvement and areas in need of attention. There have been steady declines in the asthma hospitalization rate up to 2005. In 2006, the rate declined 25%. This decline represents both a cost savings to the Texas health care systems and an improvement in quality of life for Texas's children. Another significant improvement is seen in the area of preventive health. Since 2001, there has been a 41.6% increase in the number of infants who received at least one initial periodic screen. In addition to these successes, the HSCIs identified areas for improvement in Texas. Indicators for prenatal care, low birth weight, and infant mortality all lag behind 2010 objectives. There is also a significant disparity between Medicaid and non-Medicaid populations. To address these indicators, as indicated by Health Status Indicator 6C, Texas continues to explore methods for

expanding Medicaid and CHIP coverage. In addition to expanded coverage, Texas has conducted and shared the results of a Perinatal Periods of Risk Analysis, has funded several projects aimed at addressing disparities in the adequacy of prenatal care, has analyzed and promulgated results of Texas PRAMS. Texas will continue to use data to inform initiatives and interventions that will reduce the disparities in these indicators and contribute to achieving internal state targets and national HP2010 objectives.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	35.7	34.4	25.9	28.4	25.5
Numerator	6115	6161	4745	5349	4853
Denominator	1712778	1793350	1835331	1883567	1904049
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Data Sources: Hospitalizations- Texas Hospital Inpatient Discharge Public Use Data File. Texas Health Care Information Council (THCIC), Austin, TX. 2006. Texas Population for calculation of rates- Texas State Data Center, Texas Population Estimates and Projections Programs, Texas A&M University, September 2006. 2007 is a trend based on 4 years of data.

The data is based on hospitalizations, not people in the numerator. These numbers may be under estimated of the true rate of hospitalizations for asthma because some Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the THCIC.

Notes - 2006

Data Sources: Hospitalizations- Texas Hospital Inpatient Discharge Public Use Data File. Texas Health Care Information Council (THCIC), Austin, TX. 2006. Texas Population for calculation of rates- Texas State Data Center, Texas Population Estimates and Projections Programs, Texas A&M University, September 2006.

The data is based on hospitalizations, not people in the numerator. These numbers may be under estimated of the true rate of hospitalizations for asthma because some Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the THCIC.

Notes - 2005

Data Sources: Hospitalizations- Texas Hospital Inpatient Discharge Public Use Data File. Texas Health Care Information Council (THCIC), Austin, TX. 2005. Texas Population for calculation of rates- Texas State Data Center, Texas Population Estimates and Projections Programs, Texas A&M University, September 2006.

The data is based on hospitalizations, not people in the numerator. These numbers may be under estimated of the true rate of hospitalizations for asthma because some Texas hospitals

(located in a county with a population less than 35,000) are exempt from the reporting to the THCIC.

Narrative:

The Healthy People 2010 objective is to reduce hospitalization for asthma in children 0 to 5 years of age to 25 per 10,000 or less. In 2005, the rate of hospitalizations per 100,000 declined 25% to 25.9 per 100,000. Projections for 2006 indicate that the rate of asthma hospitalizations in Texas will surpass the 2010 objective.

The Texas environment is challenging for persons with asthma. Texas is home to a diverse mix of air pollutants. The Gulf Coast region is home to one of the largest petrochemical complexes in the world. Many Texas cities have grown dramatically over the past 20 years increasing the numbers of automobiles and trucks on Texas roads. These factors coupled with the high number of days with sunshine, contribute to air pollution in most of our cities. The documented declines from the year 2000 can be attributed to the Asthma Coalition of Texas, in which the DSHS is an active participant. The work of the Asthma Coalition of Texas focuses on seven key points:

- 1) Informing health care providers, patients and families, the public, payers, employers, and governmental partners about:
 - a. The elements of evidence-based, state-of-the-art asthma care
 - b. The personal and societal burden that asthma imposes
 - c. Misconceptions and myths about asthma
 - d. Barriers to optimal asthma care
- 2) Promoting research to improve the delivery of asthma care in Texas and to delineate the role of the environment in the development and exacerbation of asthma
- 3) Communicating with local asthma coalitions, health care providers and provider organizations, patients and families, community-based organizations, and governmental partners
- 4) Disseminating information about Texas asthma projects, resources for patients and providers, developments in asthma care and research, and data on the health of Texans with asthma
- 5) Collaborating with groups to improve indoor and outdoor air quality
- 6) Encouraging and supporting activities that measure the health of Texans with asthma
- 7) Advocating for rules, policies, and laws that advance the vision of the Asthma Coalition of Texas.

In addition to the work of the Asthma Coalition of Texas, research literature has demonstrated that appropriate management by primary care providers can help avoid asthma hospitalizations. Title V will continue to work toward a continued decline in the number of proportion of uninsured children in Texas.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	93.5	98.7	96.4	100.0	100.0
Numerator	223304	245083	244236	258808	259222

Denominator	238851	248232	253418	258808	259222
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

100% reported on CMS-416. Numerator and denominator had slight differences due to data reporting system.

Source:

Texas CMS-416 FFY 2006 - 2007

Notes - 2006

100% reported on CMS-416. Numerator and denominator had slight differences due to data reporting system.

Source:

Texas CMS-416 FFY 2005 - 2006

Notes - 2005

Notes:

The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Source:

Texas CMS-416 FFY 2004 - 2005

Narrative:

From FY02 to FY06 there has been a 41.6% increase in the proportion of Medicaid enrollees aged less than one year who received at least one initial periodic screen. This percentage has exceeded 90% since 2003 and was 100% in 2006. Preventive care that starts early is essential to the lifelong health of an individual and this capacity indicator bodes well for the health of Texas' children. The improvement in this measure may be attributable to the enhanced efforts of the Texas version of the EPSDT program, Texas Health Steps, to inform caretakers of newly certified individuals on the value of preventive services. This outreach stresses the value of a medical home, the importance of preventive care, and active assistance in scheduling medical, dental and transportation services.

//2009/ In FY07, the proportion of Medicaid enrollees who received at least one initial periodic screening remained 100%. //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0.7	0.4	41.7	38.5	42.1
Numerator	5407	2823	1600	1243	944

Denominator	727434	651054	3837	3226	2243
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Prior to 2005, denominator data included all Texas SCHIP recipients.

Source:

Texas Health and Human Services Commission (HHSC).

Notes - 2006

Prior to 2005, denominator data included all Texas SCHIP recipients.

Source:

Texas Health and Human Services Commission (HHSC).

Notes - 2005

Prior to 2005, denominator data included all Texas SCHIP recipients.

Narrative:

Between 2005 and 2006, there was an approximately 3 percentage point decline in the percentage of children who are less than 1 year of age and on SCHIP who receive at least one periodic screen. In 2006, a decline in the numerator was again observed. While the proportion has not changed, there have been significant changes in the numerator and denominator of this measure. These declines accompany changes made in eligibility requirements on enrollment by the 78th Texas Legislature in 2003. These changes include: 1) decreasing the continuous coverage period from 12 months to six months; 2) increasing premiums for families above 100% of the FPL and cost-sharing for families below 185% of the FPL; 3) elimination of income deductions for items such as child care costs; and 4) implementing a 90-day waiting period for coverage. In addition to changes at the state level, new federal regulations require enrollees in CHIP to provide affirmation of their identity and their income. While these regulations may aid in the identification of families who are no longer eligible for services, they may erect a barrier to enrollment. In Texas, the Health and Human Services Commission is working to ensure that neither alterations to the state or federal eligibility requirements pose a barrier to qualified applicants. The denominator for this measure significantly changed in 2005 after an internal continuous quality improvement review of the application revealed that in previous years the denominator included all SCHIP enrollees rather than those who were less than one year of age.

In 2007, the 80th Texas Legislature revised the CHIP eligibility and enrollment requirements to return the coverage period to 12 months, reinstate income deductions for dependent care, and eliminate the 90-day waiting period. The changes will be effective 9/1/07. There will be an expected increase in the number of children eligible for CHIP services, including the initial periodic screening.

//2009/ With the changes made in CHIP eligibility and enrollment requirements during the 80th Texas Legislative Session, there was an increase in the proportion of SCHIP enrollees less than one year of age who received at least one periodic screening. The increase between 2006 and 2007 surpassed the decline between 2005 and 2006. //2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	70.3	69.9	62.6	62.2	62.4
Numerator	265305	265673	240620	245432	250341
Denominator	377374	380056	384292	394726	401286
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

The percent receiving care in the first trimester is substantially different from years prior to 2005 because of a change in birth certificate format in 2005 and how this data was calculated. Trend data for 2006 and 2007 were calculated by increasing proportion by 2% a year. Data from 2005 vital statistics are preliminary.

Notes - 2006

The percent receiving care in the first trimester is substantially different from years prior to 2005 because of a change in birth certificate format in 2005 and how this data was calculated. Trend data for 2006 and 2007 were calculated by increasing the numerator by 2% a year based on the average increase in previous years. Data from 2005 vital statistics are preliminary.

Notes - 2005

The percent receiving care in the first trimester is substantially different from years prior to 2005 because of a change in birth certificate format in 2005 and how this data was calculated. Data from 2005 vital statistics are preliminary.

Narrative:

Among projected figures for resident births in 2006 for women ages 15-44, the percentage with adequate or better prenatal care was 79.3%, which was an increase from 2005. Title V funds contractors to provide accessible, high quality, culturally competent prenatal care across Texas. However, despite this support, there supply of health care providers to fully serve the at-risk population is less than the demand with less than 10% of the population in need served. Several Texas counties have no health care providers that offer these services. In other cases, providers may not be fully cognizant of the needs of the population, especially as the demographics of Texas are changing due to an influx of new populations with diverse needs. Women's health care systems may not be working in an integrated, comprehensive manner, so appropriate and timely referrals are not made or necessary follow up does not occur. To help address provider shortages, DSHS is planning to request \$35 million from the Texas Legislature to keep pace with compensation and benefits offered in the private sector and in other states. DSHS will engage medical residency programs and continue to use the J1 Visa Waiver Program to help rural and underserved areas recruit foreign physicians. Of the 17 contracts awarded in FY06 and FY07 for the implementation of population-based projects, 10 implemented best practices to improve the

proportion of women receiving adequate prenatal care. Title V continues to work to identify solutions and strategies to aid early enrollment into prenatal care.

//2009/ After exceeding 70% in 2003, the proportion of pregnant women whose observed to expected prenatal care visits are greater than or equal to 80% has declined to 62.4% in 2007. Analysis of birth record data indicated significant geographic disparities throughout Texas. Increased attention on preconception messages and reducing unplanned pregnancy along with increased access through the implementation of the CHIP Perinatal Program may to a leveling, if not improvement, in this measure. //2009//

Health Systems Capacity Indicator 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	60.0	62.1	62.9	64.5	65.6
Numerator	1098882	1253626	1317797	1370299	1405344
Denominator	1831982	2017859	2095657	2123317	2142033
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Source:
Source: Texas CMS-416 FFY 2007.

Notes - 2006

Source:
CMS-416 FFY 1997-2006

Notes - 2005

Source:
CMS-416 FFY 1997-2005

Narrative:

Between 2002 and 2006, the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program increased from 55.4% (2002) to 64.5% (2006), an increase of 16.4%. The percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program has exceeded 60% since 2003. The Title V program monitors this figure annually as part of the grant development process. A contributor to the increase is the practice in Title V clinics throughout the state of assessing children for eligibility under Medicaid and CHIP.

//2009/ In 2007, the percent of potentially Medicaid eligible children who have received a service paid by Medicaid has increased for the fourth consecutive year. With the increased outreach among the patient population and training offerings to the Medicaid provider population, continued increases are expected in this measure. //2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	55.2	56.0	56.3	55.2	58.1
Numerator	250718	287357	301346	308987	330435
Denominator	454423	512778	535079	559406	569106
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Source: Texas CMS-416 FFY 2007.

Notes - 2006

Source:
Texas CMS-416 FFY 2006.

Notes - 2005

Source:
Texas CMS-416 FFY 2005.

Narrative:

Between 2001 and 2005, the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year increased from 51.2% (2001) to 56.3% (2005), an increase of 9.9%. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year has exceeded 55% since 2003. This improvement is attributable to several factors, including but not limited to, enhanced outreach and information, and scheduling and transportation assistance efforts provided through the Texas version of the EPSDT program, Texas Health Steps. These outreach efforts have focused on the fact that early access to preventive dental services can decrease the level of dental disease experienced by this population group and have generated an increasing number of inquiries from recipients and their caregivers about oral health. Despite these efforts, there was a decline in the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services in 2006 to 55.2%, the same percentage as in 2003. Allowances have been made to increase the reimbursement rate for dental providers which may help to reverse this decline.

/2009/ The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year was 58.1% in 2007, which was the highest percent in the five-year reporting time period. Additional increases are expected in coming years as Medicaid dental reimbursement rates increase and initiatives, such as the First Dental Home, are implemented. //2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	NaN	54.6	47.3	25.1	23.0
Numerator	0	35758	35758	21088	21145
Denominator	0	65476	75528	83891	91874
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

All SSI recipients in Texas obtain health care benefits coverage through Medicaid.

Considering the broader spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach and case management services through CSHCN Title V efforts.

Notes - 2006

Total SSI Recipients under 16

Source: SSA, Supplemental Security Record - December 2006

Total SSI Recipients under 16 Receiving Rehabilitation Services

Source: from the Health Screening and Case Management Unit and the Purchased Health Services Unit for the CSHCN Services Program.

Narrative:

The count of SSI recipients provided case management by DSHS Regional staff is not limited to only SSI recipients who are < 16 years old as specified in the Title V Application Form 17 Health Systems Capacity Measure #8. Thus, this number and the total number of SSI served by Title V may include some SSI recipients who are 16 through 20 years of age, although these recipients are thought to represent a very small percentage of the whole.

The count of SSI recipients provided case management services by DSHS Regional staff decreased from previous years due to implementation of revisions to the definition of case management services and data collection methodology in FY06.

/2009/ It appears that the indicator is stabilizing. All SSI recipients in Texas obtain health care benefits through Medicaid. Considering the broad spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach and case management services through CSHCN Title V efforts. The count of SSI recipients provided case management by DSHS Regional staff is not limited to only SSI recipients who are < 16 years old as specified in the Title V Application Form 17 Health Systems Capacity Measure #8. Thus, this number and the total number of SSI served by Title V may include some SSI recipients who are 16 through 20 years of age, although these recipients are thought to represent a very small percentage of the whole.

The count of SSI recipients provided case management services by DSHS Regional staff decreased from previous years due to continued implementation of revisions to the definition of case management services and data collection methodologies begun in FY06.

//2009//

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2005	payment source from birth certificate	9.4	7.7	8.3

Notes - 2009

Data from 2005 vital statistics are preliminary.

Narrative:

Rates of low birth weight were 8% higher in the Medicaid population. Both the Medicaid and non-Medicaid populations exceed the 2010 Objective of 5%.

//2009/ In 2007, the rates of low birth weight were 22% higher in the Medicaid population than in the non-Medicaid population. Rates in both groups continue to exceed the Healthy People 2010 Objective of 5%. //2009//

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2005	matching data files	5.9	4.9	6.5

Notes - 2009

The number of infant deaths by Medicaid status was calculated by matching 2005 death certificate data with 2005 birth data by birth certificate number. Because of limitations in the matching, the rates are considerably lower than expected. The overall infant death rate of 6.5 per 1000 live births is presented and comes from Form 12, Outcome Measure 1. This was based on 2515 deaths compared to only 2037 deaths that matched with the birth file.

Narrative:

Infant mortality was 18% higher among women whose payment source at delivery was Medicaid as compared to all other payment sources. Both the Medicaid and non-Medicaid populations exceed the 2010 Objective of 4.5 deaths per 1,000 live births.

//2009/ The infant mortality rate in 2007 was 20% greater among the Medicaid population than the non-Medicaid population. These rates are in excess of the Healthy People 2010 objective of 4.5 deaths per 1,000 live births. However, the infant mortality rate among non-Medicaid infants is lower than the US rate in 2005 (5.7 deaths per 1,000 live births). //2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	payment source from birth certificate	63.6	76.3	71.3

Notes - 2009

The percent receiving care in the first trimester is substantially different from years prior to 2005 because of a change in birth certificate format in 2005 and how this data was calculated.

Narrative:

The proportion of women enrolled in Medicaid who received first trimester care was 9% lower than women not enrolled in Medicaid. Challenges for the population enrolled in Medicaid is significant in Texas due to the high proportion of births that are to women enrolled in Medicaid (>50%). Both the Medicaid and non-Medicaid populations fail to meet the 90% standard set in Healthy People 2010.

//2009/ The proportion of women who begin their prenatal care during the first trimester is 17% lower in the Medicaid population than the non-Medicaid population. There are racial and geographic disparities in Texas that contribute to the non-Medicaid/Medicaid disparity. //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	payment source from birth certificate	59.9	63	61.9

Notes - 2009

Data from 2005 vital statistics are preliminary.

Narrative:

There is little difference in the rate of adequate prenatal care between Medicaid and non-Medicaid populations as determined by the Kotelchuck index. While there are no differences in adequate prenatal care, birth outcomes between Medicaid and non-Medicaid women persist.

//2009/ The gap in prenatal care use between non-Medicaid and Medicaid populations is less when using the Kotelchuck Index compared to enrollment in the first trimester. With the Kotelchuck index, the rate in the Medicaid population is 5% lower than in the non-Medicaid population. This may suggest that while women receiving Medicaid do not enter prenatal care early, once entered, they receive the adequate number of visits. //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	200

Narrative:

Medicaid eligibility in Texas surpasses the Federal Medicaid mandate of 133% FPL. CHIP further expands coverage to infants whose families are 200% FPL or below are eligible for CHIP in Texas. This standard is the most common eligibility standard throughout the country.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range 19 to 20)	2007	133 100 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	200

Notes - 2009

Medicaid recipients who are 19-20 either qualify for SSI and receive Medicaid, or are in transitional groups including youth transitioning from foster care.

Narrative:

Eligibility requirements for children ages 1 through 5 satisfy minimum acceptable standards established by federal Medicaid regulations. Texas also includes coverage for children 6 through 18 and in situations of extreme poverty also covers young adults ages 19 and 20, neither of which is mandated by federal Medicaid regulations. Children ages 1 through 19 whose families are 200% FPL or below are eligible for CHIP in Texas. This standard is the most common throughout the country.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	200

Narrative:

Texas has expanded Medicaid coverage to pregnant women by exceeding the federally mandated 133% FPL and allowing coverage up to 185% FPL. CHIP can also provide care to pregnant women up to 200% FPL who are not eligible for Medicaid. Further expansion of coverage to pregnant women is expected as Texas becomes the 9th state to extend specific CHIP coverage to pregnant women with unknown immigration status.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u>	3	Yes

Hospital discharge survey for at least 90% of in-State discharges		
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

Infant Birth and Death Certificates

Current Status: DSHS currently has the capacity to link birth and death records and perform analyses using this data for program planning and policy formulation purposes. The agency has the responsibility for vital statistic registration in Texas. Data are readily available.

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims files

Current Status: DSHS currently has the capacity to link birth records and Medicaid data. Texas requires significant time and resources to manage and link these types of data due to 350,000 births and millions of Medicaid eligibility records and/or claims generated per year.

Annual linkage of birth certificate and WIC eligibility files

Current Status: DSHS currently has the capacity to link birth certificate and WIC data. WIC data are readily accessible and birth record extracts for PRAMS are linked monthly to improve contact information of potential respondents in order to increase response rates.

Annual Linkage of birth certificate and newborn screening files

Current Status: Texas Newborn Screening (NBS) program tests for five disorders (PKU, galactosemia, congenital hypothyroidism and congenital adrenal hyperplasia) which if left untreated, can cause severe mental retardation, illness or death. Texas Early Hearing Detection and Intervention (TEHDI) Program is the State's universal newborn hearing screening, tracking and intervention program. Hospitals with obstetric services and birthing facilities with 100 or more births per year located in counties with population greater than 50,000 are legislatively mandated to offer newborn hearing screening (NBHS).

Hospital Discharge Surveys

Current Status: The Texas Health Care Information Council (THCIC) has responsibility for collecting hospital discharge data from all state licensed hospitals except those that are statutorily exempt from reporting requirements. Exempt hospitals include those located in counties with a population of less than 35,000 or counties with a population of more than 35,000 but fewer than 100 licensed hospital beds. DSHS acquired direct access to this database after September 1, 2004 when THCIC joined the agency. Because Hospital Discharge Data are collected using the uniform bill (UB-92) format, the data collected is administrative rather than clinical. Final data files are usually two years behind and data are available for approximately 95% of all hospital discharges. Hospital Discharge data with personal identifiers to facilitate linking cannot legally be made available; and Institutional Review Board (IRB) approval is required to obtain data elements that can serve as an identifier to link mother and child within the database. Public Data Use Files (PUDF) are available to users for a standard fee.

Annual Birth Defects Surveillance

Current Status: Texas Birth Defects Registry is a population-based registry, which collects statewide data on pregnancies affected by birth defects. The registry is based upon active surveillance of infants and fetuses with birth defects born to women residing in Texas. Texas Birth Defects Registry became statewide starting with deliveries in 1999. Records based on abstracted medical information are matched to vital records (such as birth certificates and fetal death certificates) filed with the vital records.

PRAMS

Current Status: The Pregnancy Risk Assessment Monitoring System (PRAMS) is a Centers for Disease Control (CDC) sponsored initiative to reduce infant mortality and low birth weight. PRAMS is an on-going state specific population-based surveillance system. It is designed to identify and monitor selected maternal experiences before, during and after pregnancy. A sample of about 300 mothers is drawn every month from the birth records provided by the Bureau of Vital Statistics at DSHS. PRAMS uses mixed mail and telephone modes to conduct interviews with biological mothers of infants aged 60-180 days old. Texas initiated PRAMS data collection in May 2002, and is currently one of 37 states (plus New York City and the Yankton Sioux Tribe of South Dakota) participating. Data from PRAMS can be used for research and policy related purposes. Examples of research topics conducted with PRAMS data include prenatal care, nutrition/folic acid awareness, and alcohol and tobacco use.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes
BRFSS	3	Yes
PRAMS	2	Yes
Texas School Surveys	3	Yes

Notes - 2009

Narrative:

Youth Risk Behavior Survey

Current Status: The Youth Risk Behavior Survey (YRBS) is one component of the CDC epidemiologic surveillance system developed to monitor the prevalence of youth behaviors that influence health. DSHS has direct access to and the capacity to analyze this database. YRBS is conducted biennially in selected metropolitan areas and only students 9th-12th grade in private and public schools are sampled. Therefore results may not be representative of non-metropolitan areas and data cannot be used for regional estimates.

Texas School Survey

Current Status: Texas Commission on Alcohol and Drug Abuse (TCADA) in collaboration with the Public Policy Research Institute at Texas A&M University conducted two statewide surveys of drug and alcohol use among students in elementary and secondary schools. Reports of these

surveys are currently available for 1988 through 2004. Surveys are only conducted in public schools therefore private school students and dropouts are not represented in the sample. Estimates of substance use in this survey are based on self-reports.

Behavioral Risk Factor Surveillance System

Current Status: The Behavioral Risk Factor Surveillance System (BRFSS) is one component of the CDC epidemiologic surveillance system developed to monitor the prevalence of behaviors among adults (ages 18 and older) that influence health. For the 2007 and 2008 BRFSS administration in Texas, questions were added that addressed breastfeeding, family planning, and oral health. DSHS has direct access to and the capacity to analyze these data. Additional funding has allowed for oversampling among Texas' border populations which should yield new information useful to programs. All data are self reported through telephone interviews.

PRAMS

Current Status: While DSHS has direct access to these data, Texas PRAMS does not currently meet CDC's requirement of a 70% response rate per sample strata. PRAMS data are collected statewide and available data cannot be used for regional or local estimates. All data are self-reported. Currently, data analyses are being conducted internally to influence policy and service delivery in the Title V program.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The concept of performance measures has contributed greatly to ensuring accountability, not just for Title V staff to assess the progress Texas makes from year to year, but also to compare Texas' status and progress with those of other states. At a time when budgets are constrained and resources are tight while the demand for services increases, the performance measures help to frame and focus the efforts of Title V programs and the resources that support them. Two other concepts that have helped are the pyramid of MCH service levels and outcome measures. The latter provide a long-term focus for Title V activities while national and state performance measures provide short-term focus. The link between the two types of measures means that activities designed to advance the state toward meeting short-term measures will lay the foundation and initiate progress toward achieving long-term outcome measures. The pyramid enables Title V staff to view how funds are proportioned across direct health care, enabling services, population based services and infrastructure building services to ensure that there is an appropriate balance of funds that reflect the different needs in Texas.

During the current needs assessment process, Title V partners and stakeholders identified an overwhelming number of needs related to the Title V populations. Title V staff categorized the needs according to pyramid levels. Next, staff used stakeholder input and their own knowledge and expertise to determine which of the identified needs were most significant to the Texas Title V populations. While most critical needs were aligned and reflected in the national performance measures, others were addressed through the development of state performance measures with activities linked to MCH service levels as outlined in the pyramid. Through this process, staff members are able to assess and address the critical needs of the state.

Since 2000, Texas has met two of the six national outcomes measures: the postneonatal mortality rate per 1,000 live births and the child death rate per 100,000 children aged 1-14. One, the ratio of black infant mortality to white infant mortality has remained the same. The remaining outcome measures, infant mortality, neonatal mortality and perinatal mortality, have increased. The 2004 postneonatal mortality rate of 2.1 live births per 1,000 is an improvement from the 2000 rate of 2.3. The child death rate per 100,000 is the lowest it has been in five years, 22.8, an improvement from the 2000 rate of 24.2. The 2004 infant mortality rate of 5.8 per 1,000 live births has increased from the 2000 rate of 5.7. Similarly, at 3.7, the 2004 rate of neonatal mortality rate per 1,000 live births is higher than the 2000 rate of 3.4. At 9.2, the perinatal mortality rate per 1,000 live births plus fetal deaths is higher than the 2000 rate of 8.9.

/2007/ Projections for 2005 outcome measure data indicate that Texas continues to meet or exceed the outcome measures for postneonatal mortality and the child death rate, ages 1-14. Overall infant mortality decreased slightly from 5.8 to 5.7 but the ratio of black to white infant mortality increased from 2.4 to 2.5, indicating a state trend that mirrors national statistics for this disparity. Neonatal mortality remained steady at 3.7, postneonatal mortality decreased for the third consecutive year to 2.0, and overall perinatal mortality decreased for the third consecutive year to 9.1. However, the projected ratio of black to white perinatal mortality increased to 2.4. The child death rate decreased for the third consecutive year to 21.8. Since 2002, Texas has either closely met or exceeded the annual objective for child death rate, ages 1-14.

The indicators on infant mortality identify the challenge that Texas continues to face in reducing mortality outcomes for infants less than 28 days of age, especially among African Americans and adolescent mothers. Since the research literature clearly links these outcomes to maternal health and the adequacy of prenatal care, Texas will continue to implement activities that target populations and areas of the state where these risk groups are most prevalent.

State measures and activities that are intended to further reduce the rate of child deaths, ages 1-14, include activities such parent education and distribution of child safety seats through Safe

Riders, support of the DSHS Youth Suicide Prevention Project, conduct Perinatal Periods of Risk (PPOR) analysis, and a variety of activities related to childhood issues such as obesity prevention, dental care, and school readiness. Additionally, the responsibility for Child Fatality Review was integrated into the Title V Office in 2006, allowing Title V staff to have direct input into policies that can prevent child deaths. //2007//

The prevailing trend is slow progress for most of the mortality outcome measures and minimal or no progress for the outcome measures dealing with racial and ethnic disparity. This trend indicates that Texas has been more effective in developing activities that improve outcomes for older infants and children, but is still struggling to find the most effective blend of activities to improve outcomes for fetuses and neonates and to address disparities. These outcome measures reflect the health status of pregnant women and newborns and relate to the pre-pregnancy, perinatal and neonatal environments so efforts must be targeted to address these areas. Many of the activities in the FY06 plan are designed to address these trends, although activities and resources must also continue to focus on improving the progress made in the other outcome measures.

Some of the factors that impact performances and outcome measures are beyond the control of the Texas Title V program. While Title V can identify specialized facilities that care for high-risk neonates, it cannot ensure that facilities exist in all parts of the state that need them. /2007/Data analyses will seek to identify hospitals that may not be referring deliveries to high-risk facilities. These hospitals will be targeted for education.//2007//

The five-year needs assessment clearly shows that the Title V populations in Texas continue to have unmet needs linked to the MCH service levels, and the performance and outcome measures. Texas Title V will continue to use these tools to develop the FY06 and future activity plans to ensure the greatest success in improving outcomes for Texas families.

B. State Priorities

Title V is concerned about the health and well being of all Texas residents. As shown in the needs assessment section, indicators show improvement in many areas of the health of Texas' population. Others, however, show discouragingly little progress. As part of Texas' effort to improve health status and eliminate health disparities within the entire Title V population, Title V staff members include the following priority focus areas, highlighting priority needs for this reporting period. The priority focus areas are organized by population group and service levels of the pyramid.

/2007/ No updates were added for FY07. //2007//

/2008/ The following priorities remain consistent with the mission of DSHS and the Title V Program to promote optimal health for individuals and communities while providing effective health, mental health and substance abuse services to Texans.//2008//

/2009/ The priorities highlighted below continue to be the focus for DSHS and the Title V Program. The only specific change is the additional priority related to children with special health care needs to increase provider participation in the CSHCN Services Program.//2009//

I. Women and Infants

Infrastructure Building

Reduction of domestic violence

Title V stakeholders identified domestic violence as a priority need for women and infants in the 2005 needs assessment. Reducing the incidence of domestic violence has been a priority need in

Texas for Title V since being added as a state priority in 2002. The need has been well documented. In 2002, researchers conducted the first surveys of sexual assault and domestic violence prevalence in Texas, providing critical state-level data that documented the need (Busch et al., A Health Survey of Texans, 2001; and Texas Council on Family Violence, Prevalence, Perceptions, and Awareness of Domestic Violence in Texas, 2003.) The survey, which focused on sexual assault, found that nearly two million Texans have been sexually assaulted at some time in their lives and that nearly one in ten Texas girls were assaulted before they reached age 14. The domestic violence study reports the problem as an epidemic in Texas, with 47 percent of all Texans having been abused in their lifetimes. Both studies confirm that these forms of violence are underreported. The Healthy People 2010 goal for intimate partner violence is to reduce it to 3.6 physical assaults per 1,000 persons aged 12 years and older. Texas does not maintain statistics in a manner consistent with HP 2010, but available data would indicate that currently, the rate in Texas is much higher.

In Texas as elsewhere, gaps in rigorous research, data collection and evaluation make effective prevention efforts for domestic violence difficult to define or implement. In order to build infrastructure, state agencies are working collaboratively with service providers, research institutes and advocates to create shared methods of tracking relevant data. DSHS Title V staff have taken a lead in coordinating the collaborative efforts to promote engagement of local communities across the state in violence prevention through active local coalitions and by serving as a resource for local and regional staff in building successful coalitions. Texas stakeholders want to know what works to end sexual assault and domestic violence in their communities so that they may utilize limited resources effectively.

Population-Based

Reduction of obesity among women (new need)

Obesity has been discussed for several years as one of the major public health issues facing the country. Texas data parallel a national trend of increased overweight and obesity. The state is not immune to this problem with overweight rates as high as 39.1% and obesity rates as high as 33.6% for women of childbearing age in some parts of Texas (BRFSS, 2003). These rates have steadily increased over the years and projections predict a continued trend. Healthy People 2010 goals for weight status include increasing the proportion of adults who are at a healthy weight to 60% and reducing the proportion of adults who are obese to 15%. Healthy weight is defined as having a body mass index of more than 18.5 but less than 25. Clearly the rate of overweight and obesity among Texas women is higher than the national target. The problem is exacerbated by the fact that no one solution exists to address the problems of overweight and obesity, although poor nutrition and decreased physical activity are linked. Trends in overweight and obesity are a reflection of the rapid changes society has undergone, including the increase of labor saving devices, the ready availability of a multitude of inexpensive, processed foods and the constant demands on time that many family members face. These same factors have led to decreased physical activity. Additionally, mental health issues such as low self-esteem, depression and emotional trauma can contribute to overweight and obesity. While recent research does not strongly support whether overweight and obesity will replace smoking as the leading cause of morbidity and mortality, it is clear that they are associated with diabetes, cardiovascular disease, mobility problems and reduced quality of life. It is also clear the learned habitual behaviors of adult family members around poor nutrition and decreased physical activity often lead to the development of the same behaviors in the children. Research indicates that the earlier in life a child faces overweight and/or obesity, the more challenging it will be to obtain and maintain a healthy weight later in life and the earlier the child may face some of the concomitant physical problems.

Additionally, certain data show a link between obesity during pregnancy and the incidence of neural tube defects, some of which can be fatal or can severely compromise the child. There is also some data that indicates that when the mother is obese, there is higher risk of prematurity, delivery complications and cesarean delivery, all of which can potentially lead to increased perinatal, infant, neonatal, postneonatal and child mortality. Since the incidence of obesity is high

among African American women, it may play a role in the infant death disparity.

Although reducing adult obesity is a new priority for Texas, early research is showing that multi-factor interventions can have a positive impact on the rate of overweight and obesity. (William H. Dietz, M.D., Ph.D., CDC's Role in Combating the Obesity Epidemic, Statement before the Senate Committee on Health, Education, Labor and Pensions, May 21, 2002.) While much remains unknown about the impact of overweight and obesity on perinatal outcomes, what is known confirms that being at a healthy weight going into pregnancy increases the likelihood of a less complicated pregnancy and delivery.

Reduction of fetal and maternal exposure to smoking, alcohol and other substances (new need)
A number of stakeholders responding to the Title V Needs Assessment Survey identified reducing fetal exposure to tobacco, alcohol and illegal drugs as a top priority. However, Texas does not have a reliable mechanism in place for measuring alcohol consumption and illegal drug use during pregnancy. Furthermore, because Fetal Alcohol Spectrum Disorder (FASD) is often not screened for or diagnosed at birth or even in the first year of life, it is difficult to get an accurate assessment of the incidence. Consequently, the focus will be to reduce fetal exposure to tobacco.

At 17.6%, the smoking rate among women of childbearing age is lower than the national average (20.3), but considerably higher than the Healthy People 2010 target rate of 12%. In some parts of the state, such as Central Texas (Health Service Region 7), the overall smoking rate is as high as 24.3%. Incidence of smoking is highest among the White population (23.7) and lowest in the Hispanic population (18.7). It is also highest among individuals ages 18-29. Because of the addictive qualities of nicotine, quitting smoking can be very challenging. Women may be particularly reluctant to discontinue smoking due to fears of weight gain. Also, because smoking is considered a stress reducer, individuals may be reluctant to seek healthier alternatives.

Research indicates that smoking increases numerous risks to mothers and infants, including cancer and cardiovascular risks to the mother, and prematurity, low birth weight, SIDS, asthma and cancer risks to the child, which can lead to increased perinatal, infant, neonatal, postneonatal and child mortality. Decreasing or discontinuing smoking can yield immediate health benefits that increase over time. While nicotine is known to be addictive research has shown that in many cases, women will decrease or discontinue smoking during pregnancy simply at the request of a health care provider (Boschert, Sherry. Use 'five A's' in smoking cessation counseling: brief interventions make big difference - Clinical Rounds, OB/GYN News, Jan. 15, 2005). Quitlines, especially when used in a proactive manner, such as Quitline staff contacting a consenting individual, are also considered efficient and effective (Tobacco Use Cessation: The Effectiveness of Quit Lines, National Conference of State Legislators, <http://www.ncsl.org/programs/health/tobaccostop.htm>.)

II. Children and Adolescents

Population-Based

Reduction of obesity among children

Obesity is linked to decreased physical activity, diabetes, cardiovascular disease, joint pain, mobility problems, and other long-term health complications. Texas mirrors the national trend of increased overweight and obesity in children. In 2003, the national average was 13.5% while Texas was slightly higher at 13.9%, both increasing from approximately 10% in 1999. The highest incidence in Texas children ages 1-4 is among Hispanics, which continues to be a rapidly growing population within Texas. Preventing obesity is a priority objective for the Governor of Texas and the DSHS Commissioner. After reviewing both perceived and actual needs, Title V subject matter experts and stakeholders identified obesity as a critical issue and thus selected it as a state priority need. While many evidenced-based interventions exist to curb obesity among children, it is strongly believed that teaching parents of very young children healthy nutritional habits can positively impact children through adulthood and minimize the number of chronic diseases

associated with overweight and obesity. Thus, the desired outcome of the reduction of obesity is intended to decrease the child death rate per 100,000 children aged 1-14.

Infrastructure Building

Increase access to dental care (new need)

Lack of access to dental care results in untreated dental caries and other oral health problems. Possible negative health outcomes may include chronic mouth pain, disrupted eating patterns, weight loss, and loss of school and work time for families (economic damages). Dental caries are 5-7 times more common than reported respiratory disease among 5-17 year-old youth. While many factors contribute to dental caries, in 2004, studies show, nationally, children living in poverty have four times more dental caries than those families with income levels above the federal poverty level. Texas ranks 44th among the U.S. with the greatest percentage of children in living in poverty. Even those qualifying for government-assisted care may not receive services. In 2003, only 47% of children age 1-14 who were Texas Health Steps eligible received oral health screens. Access to dental providers and services is especially a problem among those who live along the Texas/Mexico boarder or in rural areas. After reviewing both perceived and actual needs, the Title V subject matter experts and stakeholders identified access to dental care as a critical issue and thus selected it as a state priority need. Dental caries and/or tooth decay is the most common childhood chronic disease and is largely preventable. Left untreated, tooth decay can lead to abscesses and infections, pain, dysfunction and weight loss. In an effort to decrease the child death rate per 100,000 in children aged 1-14, access and timeliness of access to services can equate to healthier outcomes.

Improve and expand healthcare infrastructure (new need)

Early and periodic screening results in fewer adverse health outcomes. In 2004, 52% of Texas counties were designated as Health Professional Shortage Areas. As a result, less than 60% of children eligible for Texas Health Steps were screened in 2003. Twenty-one percent of Texas children live in poverty, as compared to a 16% US average and 22% of Texas children are without health insurance as compared to 12% nationally. Research has shown that access to alternative sources of health information is vital in creating a thriving population. After reviewing both perceived and actual needs, the Title V subject matter experts and stakeholders identified increasing the healthcare infrastructure as a state priority need. By establishing links between childcare health and/or medical consultants and the early care and education community, information and resources on child health and safety can be provided as well as parent education, family support, social emotional development, and medical home information. The intent is to develop a system to provide families and communities the necessary support and information to make healthy decisions regarding their families. The intended outcome is to decrease the child death rate per 100,000 children aged 1-14 within the state of Texas.

Through the Federally Qualified Health (FQHC) Incubator Grants Initiative, DSHS provides funding and technical assistance to local entities interested in pursuing FQHC designation so they can develop a competitive application at the federal level. The Texas Primary Care Office (TPCO), located within the Office of Title V and Family Health, collaborates with the Texas Association of Community Health Centers (TACHC) to provide training and TA to these entities. Both TACHC and TPCO share the common goal of growing the number of FQHCs serving the state, thereby improving access to care for low-income families in underserved areas. TPCO is under the oversight of the State Title V Director.

/2009/ Current law authorizing the FQHC Incubator Grant program will expire at the end of FY 2009. The Title V and Family Health Primary Care Office has contracted with East Texas Area Health Education Center at University of Texas Medical Branch to conduct four focus group meetings across the state in July and August to gather input on improving the program. Tentative locations include Houston, San Antonio/South Texas, Dallas/East Texas, and Midland/West Texas. These meetings will be strategically planned for areas where the greatest numbers of FQHCs, FQHC Look Alikes, current and former Incubator contractors, or other safety net providers are located. Input will be used to evaluate

potential changes to the program in FY 09 and to any legislation proposed during the 81st Legislature. //2009//

III. CSHCN

CSHCN SP considers all six of the national and state performance measures for which it is responsible to be priorities as confirmed by the needs assessment. However, for the list of ten Title V state priorities (which include consideration of the priority needs of women, infants, children, and adolescents, the CSHCN SP prioritized the following four state priority needs:

- 1) Increase partnerships with families of CSHCN in decision-making at all levels and family satisfaction with the services they receive (NPM 2) (Enabling and Infrastructure-Building Services)
- 2) Increase the number of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home (NPM 3) (Enabling and Infrastructure-Building Services)
- 3) Improve the organization and coordination of community-based service systems for CSHCN and their families so that an increased number of families of CSHCN report that these systems are easy to use (NPM 5) (Enabling and Infrastructure-Building Services)
- 4) Increase the number of youth with special health care needs who receive the services necessary to make transition to all aspects of adult life (NPM 6) (Enabling and Infrastructure-Building Services)

The four selected state priorities (NPM 2, 3, 5, and 6) reflect the current capacity and focus of Title V activities and influence. Due to the interconnectedness of all the Title V CSHCN performance measures, the activities in these areas incorporate activities to achieve NPM 4 and SPM 1 as well. Specific activities for all national performance measures and the one state-added performance measure are planned in FY06.

Please see the 5-Year Needs Assessment, Section II.B.5, Selection of Priority Needs (CSHCN-specific narrative) and Form 14 for additional information.

/2008/For FY08, the CSHCN SP will focus specific efforts on the following measures: Increase partnerships with families of CSHCN in decision-making at all levels and family satisfaction with the services they receive (NPM2); Increase the number of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home (NPM3); Increase the number of youth with special health care needs who receive the services necessary to transition successfully to all aspects of adult life (NPM6); and Reduction of institutionalized CSHCN (SPM1). In addition, CSHCN SP will continue efforts to address the remaining measures (NPM 4 and 5) through activities described in this application.//2008//

/2009/ For FY09, the CSHCN SP will focus specific efforts on the following areas: Increase partnerships with families of CSHCN in decision-making at all levels and family satisfaction with the services they receive (NPM2); Increase the number of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home (NPM3); Increase recruitment and retention of CSHCN Services Program providers (as part of NPM4); Increase the number of youth with special health care needs who receive the services necessary to transition successfully to all aspects of adult life (NPM6). In addition, the CSHCN SP will continue efforts to decrease the number of institutionalized CSHCN and to improve the organization of community-based services systems for easy use by families of CSHCN. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	95	95	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	426	383	377	370	433
Denominator	426	383	377	370	433
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

Denominator is number of confirmed cases as indicated on Form 6.

Notes - 2006

Denominator is number of confirmed cases as indicated on Form 6.

Notes - 2005

Denominator is number of confirmed cases as indicated on Form 6.

a. Last Year's Accomplishments

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures. The Newborn Screening Laboratory Quality Assurance Officer will provide monthly unsatisfactory specimen collection reports to the Case Management Program and assist in developing training and educational materials.

Update: Of the 396,000 initial specimens received, 7,943 (2%) were deemed unsatisfactory. NBS contacted 265 providers and distributed the following educational materials: 684 Practitioner's Guides; 173 New Submitter Packets; 989 Weight Conversion Charts; 1,568 Specimen Collection Guides; 1,801 Specimen Collection Posters; 103 CD Slide Presentations; 21,311 Newsletters; and 4,296 Urgent Message Flyers.

NBS Program expanded the screening panel to 27 disorders in FY07. The program now screens for six amino acid disorders; two endocrine disorders; five fatty acid oxidation disorders; three hemoglobinopathies; nine organic acid disorders; and two other disorders. (See Form 6 for details.) All information on expanded screening was presented on the NBS web site, including an online publication order form for new literature, CDs, the Laboratory Voice Response System, NBS Telephone Directory, and revised Laboratory Specimen Reporting Format.

Educational materials were created for physicians and parents. Revised brochures were developed in English, Spanish, and Vietnamese. Slide presentations were updated to include the additional disorders and revised laboratory specimen results reporting formats. NBS created an Online Provider Education Program consisting of a number of self-paced, web-based training modules on newborn screening which provided free continuing education to participants.

In FY07, the program hired a second educator, specifically for providing on-site in-service training. During the year, the NBS provided 137 such trainings in 46 cities throughout the state. In

addition, specimen collection training was provided in Lubbock, Nacogdoches and Tyler.

A project to develop report cards was completed. The first report card was mailed in June 2007, providing program statistics to submitters, including the number of newborn screens submitted, transit times from specimen collection to receipt in the DSHS laboratory, and the number of unsatisfactory specimens grouped by specific quality issues.

Activity 2: Educate parents and health professionals about newborn screening benefit and state requirements by distributing brochures on newborn screening to health care providers, placing information regarding newborn screening on the newborn screening website, and making an email address available for any questions regarding newborn screening.

Update: NBS distributed 367,115 brochures, 665 posters, and counted 460,409 visits to the NBS website in FY07. NBS also contacted over 4,000 health professionals through newsletters and special postcards in preparation for the expansion of the newborn screening panel, including promotion of the new parent education materials. Direct mailings were also initiated to 150 midwives, 330 birthing hospitals, 480 public libraries and 2,610 OB/GYNs.

The NBS Program Medical Consultant presented information at the following venues: Pediatric Grand Rounds at Medical City Dallas; the Texas Medical Association, including the Council on Scientific Affairs and the Maternal and Perinatal Health Committee in Austin; the Texas Association of Family Practitioners 2006 Primary Care Summit in Houston; the DSHS Perspectives in Health Conference in Austin; to DSHS El Paso Regional Office; and the Perinatal Conference at the Medical Center of Plano.

As part of the Annual Maternal PKU Project, NBS staff contacted parents of all female patients aged 13 years diagnosed with PKU to alert the parents to the appropriate treatment during pregnancy. NBS mailed 13 packets of information including "The Young Woman with PKU" and "Lets Focus on PKU and Pregnancy for Adolescents with PKU Ages 11-15 Years Old" and "The Young Woman with Mild Hyperphe."

Performance Assessment: Between 2003 and 2007, NBS met the annual objectives with 100% follow-up and case management of identified presumptive positives through increased awareness of the legal requirements for newborn screening and continued technical assistance to minimize the number of unsatisfactory tests.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures.			X	
2. Educate parents and health professionals about newborn screening benefit and state requirements and importance of follow-up to positive tests.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: There were 206,739 specimens collected during the first two quarters of FY07 with 1,500 unsatisfactory specimens (0.72%). There have been 216 contacts made with providers and educational materials were distributed widely. During this reporting period the Texas Newborn Screening Program provided 126 on-site in-service education visits at 39 sites throughout the state.

Activity 2: NBS distributed 8,610 newsletters to over 4,000 health professionals/stakeholders. Packets of specimen collection materials were distributed to 86 Schools of Nursing. NBS educational materials and in-service education were sent to 64 local health departments and 1,889 Texas OB/GYNs.

Planning and implementation of sickle cell screening has begun. In the 2nd Quarter of FY 08, NBS notified families by letter of newborn children that are identified as having sickle cell trait. Families receive a certified letter from NBS as well as an educational brochure and a resource list of sickle cell associations in the state. From Dec 3, 2007 thru Feb 29, 2008, 1,673 sickle cell trait notification letters were mailed.

c. Plan for the Coming Year

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures.

Output Measure (s): Percent of total newborn screens that are unsatisfactory; number of providers identified as submitting unsatisfactory specimens; number of contacts made with providers identified as submitting unsatisfactory specimens; number and type of educational materials distributed.

Monitoring: Monthly review of percent increase/decrease in unsatisfactory specimens and tracking of dissemination of materials.

Activity 2: Educate parents, including expectant parents and parents of newborn children, and health professionals about newborn screening benefit, state requirements, and importance of follow-up to positive tests by distributing brochures on newborn screening to health care providers, providing Information for Parents of Newborn Children pamphlets for distribution by 65 health care providers and facilities to all expectant and postpartum parents, placing information regarding newborn screening on the NBS Program website, and making an email address available for any questions regarding newborn screening.

Output Measure(s): Type and number of materials distributed and website hits.

Monitoring: Ensure distribution of materials and document interactions with stakeholders.

Activity 3: Revise the Office of Title V publication Information for Parents of Newborns and make available on the MCH web page.

Output Measure(s): Revised brochure in English and Spanish.

Monitoring: Ensure posting of brochure on website and notification/distribution to key stakeholders.

Activity 4: Identify tangible measures that link the quality of patient care with the quality of pre and post-analytical stages of the newborn screening process.

Output Measure(s): Establish evidence-based best practices in the areas of pre- and post-analytical stages of the newborn screening process that will serve as a model for nationwide replication.

Monitoring: Track progress a regularly scheduled steering committee meetings.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	57.1	57.2	57.3	57.4	57.5
Annual Indicator	57.0	57.0	57.0	57.0	57.9
Numerator	142384	142384	142384	142384	450786
Denominator	249840	249840	249840	249840	778339
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	58	58.1	58.2	58.3	58.4

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Activity 1: Support and enhance mechanisms for partnering in decision-making with families of CSHCN and promoting family networking.

Update: CSHCN SP staff and contractors participated in local, regional, and state-level advisory groups and gathered family and other stakeholder input through these and other forums. During FY07, CSHCN Services Program (SP) staff and contractors reported input from stakeholder meetings attended by over 12,500 participants, including more than 3,600 family members. Stakeholders' key concerns included: 6-month re-enrollment for Medicaid and CSHCN SP health care benefits, wait lists for children to receive needed care, the lack of available care for the undocumented and in rural areas. Stakeholder concerns about 6-month re-enrollment for CHIP were addressed by the 80th Texas Legislature which extended CHIP coverage to one year.

In response to SB 1188, the Health and Human Services Commission (HHSC) hired an independent contractor, Navigant Consulting, to conduct an in-depth study of case management services and to make recommendations for optimization of the case management system in Texas. The HHSC contractor solicited stakeholder feedback through consumer/provider focus groups, consumer/family satisfaction surveys, and interviews with consumers/families, case managers, and advocates. CSHCN SP staff and contractors assisted in identifying families to participate in focus groups and interviews.

CSHCN SP staff also used email, listservs, and surveys to solicit stakeholder input on families' experiences with the doctor or nurse their child sees the most and with their health insurance. One email survey asked families about their understanding and use of listservs as a mechanism to obtain information and for communication with other families. Survey results were used to begin exploring listserv opportunities for communicating with families and obtaining family stakeholder input. CSHCN SP staff surveyed contractors regarding their contact with families by email which may be a future mechanism for obtaining periodic input from families. Family Voices developed a small coalition of family leaders and community organizations from across Texas to foster relationships and communication that may help the state identify and address needs. CSHCN SP contractors continued to provide opportunities for parent education, leadership, and networking.

Activity 2: Monitor consumer satisfaction with CSHCN Services Program contractor services.

Update: CSHCN SP contractors survey families to determine levels of satisfaction with contractor services and to obtain input for recommended program improvements. During FY07, 1,720 families served by CSHCN SP contractors responded to a contractor satisfaction survey. Families indicated a very high level of satisfaction with contractor services as 98.6% indicated satisfaction on 75% or more of survey questions. Responses gauged satisfaction and provided recommendations for program improvements. CSHCN SP staff recommended questions to contractors to incorporate into existing surveys and continued to develop a set of "core questions" for use by all contractors as a means of measuring satisfaction more consistently across contractors.

Activity 3: Assess consumer satisfaction with CSHCN Services Program health care benefits and with state service systems in general.

Update: The CSHCN SP implemented a Consumer Satisfaction Plan to identify surveys and other mechanisms for feedback from families. CSHCN SP staff implemented a survey to gather information from families regarding their satisfaction with their health insurance coverage. The survey was mailed to families as an insert in the CSHCN SP Newsletter for Families and was also available online. CSHCN SP staff also completed a survey of program clients regarding their medical home.

Performance Assessment: The 2005/06 National Survey of CSHCN (NS-CSHCN) reported that 57.9% of Texas families of CSHCN aged 0-18 responded that they are partners in decision-making and are satisfied with the services they receive, as compared to 57% of Texas families noted in the 2001 NS-CSHCN. Additional analysis of the 2005/06 NS-CSHCN data will continue. Client/family surveys in FY07 consistently reported high levels of satisfaction with case management, clinical services, and family supports or community resource services provided through CSHCN SP contractors.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support and enhance mechanisms for partnering in decision-making with families of CSHCN and promoting family				X

networking.				
2. Monitor consumer satisfaction with CSHCN Services Program contractor services.				X
3. Assess consumer satisfaction with CSHCN Services Program health care benefits and with state service systems in general.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: CSHCN SP staff and contractors participate in family listservs and local, regional, and state-level advisory groups. Stakeholder input and concerns are identified through these and other forums. During the first half of FY08, CSHCN SP staff reported input from 35 stakeholder meetings attended by nearly 2,000 participants, including 400 family members. Regional staff attended over 1,000 community events. CSHCN SP contractors reported input from 222 events attended by nearly 7,800 participants, including over 2,200 family members. Key concerns listed by stakeholders are: 6-month renewal requirement for Medicaid and CSHCN SP health care benefits and waiting lists for needed services. CSHCN SP staff assisted in the appointment of a family representative on the Consumer Direction Workgroup. A CSHCN SP staff person is the Family Delegate to AMCHP, was accepted as an AMCHP Family Mentor and Family and Youth Leadership Committee member, and attended FY08 Conference.

Activity 2: More than 100 families responded to contractor surveys: 97% indicated satisfaction on 75% or more of survey questions. Responses gauged satisfaction and stated ways to improve. CSHCN SP staff received permission to adapt the Ohio Family Support Council Family Friendly Assessment to be sent to CSHCN SP contractors and providers in July '08.

Activity 3: The CSHCN SP will hold stakeholder focus groups at contractor site visits and events, and implement an annual survey for input in FY08.

c. Plan for the Coming Year

Activity 1: Support and enhance mechanisms for partnering in decision-making with families of CSHCN and promoting family networking.

Output Measure(s): Monitor active CSHCN/ family listservs and key CSHCN stakeholder groups with significant CSHCN/ family membership (including contractor advisory groups) for identification of information to be used in feedback, needs assessment, and satisfaction measures; develop or revise activities based on specific input from families.

Monitoring: Routine collection and analysis of listserv interfaces, Stakeholder Meeting Records, and contractor quarterly reports; documentation of program discussions and use of consumer inputs in decision-making. Collect and analyze listserv dialogue for review and integration into activities.

Activity 2: Monitor consumer satisfaction with CSHCN Services Program contractor services.

Output Measure(s): Indicators of level of satisfaction with CSHCN Services Program contractor services, including Contractor quarterly reports regarding satisfaction survey results and the percentage of their clients who are satisfied with core topic areas as well as other services they receive through the contractor; tracking of "priority concerns/suggestions relevant to CSHCN"

from the Contractor Stakeholder meeting section of quarterly report into central office Stakeholder Meeting Report; recommendations/ input from consumers; and contractor response to consumer feedback.

Monitoring: Review contractor quarterly reports.

Activity 3: Assess consumer satisfaction with CSHCN Services Program health care benefits and with state service systems in general.

Output Measure(s): Consumer satisfaction assessment activities implemented and incorporated into unit QA plan; satisfaction data gathered via phone and websites; data analysis; and recommendations made/actions taken based on results; indicators of level of satisfaction with CSHCN Services Program health care benefits and with state service systems in general within the context of Title V Performance Measures as noted through Stakeholder Meeting Records, Contractor quarterly reports of priority concerns/suggestions relevant to CSHCN, their families, and focus groups.

Monitoring: Documentation of progress, barriers, and results.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	58.4	58.5	58.6	58.7	58.8
Annual Indicator	58.3	58.3	58.3	58.3	46.3
Numerator	399631	399631	399631	399631	351768
Denominator	685206	685206	685206	685206	759974
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	46.4	46.5	46.6	46.7	46.8

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Numerator and denominator are weighted estimates.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Activity 1: Provide leadership to, and collaborate with members of the Medical Home Workgroup (MHWG) to increase awareness and knowledge of the medical home concept and practice among all relevant audiences and to promote medical home services and quality improvements.

Update: The MHWG met quarterly to implement the strategic plan. Members participate in the Texas Early Childhood Comprehensive Systems Initiative (Raising Texas) and Access to Insurance and Medical Home workgroup. MHWG members also assisted in a cross-agency quality assessment effort related to CSHCN.

MHWG members partnered with THSteps (EPSDT) to implement online provider education modules for physicians and other health care providers, including an Introduction to Medical Homes. MHWG members representing two Texas health plans participated in national research conducted by the Center for Medical Home Improvement. The Texas Association of Community Health Centers partnered with the MHWG to provide FQHCs with medical home information and quality improvement tools.

The CSHCN Services Program (CSHCN SP) supported Texas Parent to Parent's (TXP2P) successful application for a HRSA/MCHB Family to Family Health Information and Education Center grant. TXP2P provided medical home awareness community training, distributed over 1500 Medical Home Family Toolkits, and worked with other MHWG members to enhance family/ and health professional collaboration. CSHCN SP staff provided workshops on medical home and transition at the 2007 Texas Parent to Parent Annual Conference.

A bilingual booklet, "Emergency and Disaster Planning for CSHCN", was sent to CSHCN SP health care benefits clients to help families plan and be better prepared for an emergency or disaster. A link to the booklet was posted on DSHS and AAP webpages. A survey sent with the booklet asked families about their experiences with the doctor or nurse that their child sees the most. The results of the survey regarding 14 medical home characteristics included that 66% of respondents noted that their doctors or nurses implemented more than half of these characteristics. Twenty percent noted that their doctors or nurses implemented 5 or fewer of the 14 characteristics to rank "low" or "very low" on a scale of "medical homeness."

MHWG members presented information on practical implementation of a medical home for CSHCN, including practice office management tools and appropriate coding and reimbursement strategies for the Medical Directors of Texas' managed care organizations for CHIP and Medicaid services and at the Texas Pediatric Society Annual Meeting. CSHCN SP staff highlighted Texas' medical home collaborative efforts in a poster session at the AAP Future of Pediatrics Conference.

The Clinician-Directed Care Coordination Policy covering reimbursement for face-to-face and non-face-to-face care coordination for children served in the Medicaid Program and CSHCN SP was implemented 9/1/07. MHWG members will consider other reimbursement and incentive strategies to help support medical homes in Texas.

A new health care program to ensure a medical home and a health passport for children in foster care will be implemented in 2008. The DSHS Immunization Branch actively promotes the medical home as a strategy to improve vaccine coverage levels. The Texas Council for Developmental Disabilities noted the medical home as a feature of access to comprehensive care in the updated "Access to Health Care" position statement.

Activity 2: CSHCN Services Program regional staff and contractors help CSHCN link to medical homes.

Update: During FY07, 87% of CSHCN receiving case management and clinical services from DSHS regional staff and CSHCN SP contractors had a primary care provider (PCP). Over 750

CSHCN were assisted in obtaining a PCP. CSHCN SP contractors provided information on medical homes to families and providers through Grand Rounds and Medical Residency Educational programs.

Performance Assessment: The 2005/06 NS-CSHCN reported that 46.3% of Texas CSHCN aged 0-18 received coordinated, ongoing, comprehensive care within a medical home. This measure is not comparable across survey years due to changes in survey questions. Additional analysis of the survey data will continue. Awareness of the medical home concept continues to increase for families, primary care practitioners, third party payors, state agency personnel, and other stakeholders.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide leadership to, and collaborate with members of the Medical Home Workgroup (MHWG) to increase awareness and knowledge of the medical home concept and practice among all relevant audiences and to promote medical home services and quality improv				X
2. CSHCN Services Program regional staff and contractors help CSHCN link to medical homes.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The MHWG met quarterly to implement the strategic plan. Members continue to be active in the Texas Early Childhood Comprehensive Systems Initiative (Raising Texas) and Access to Insurance and Medical Home team. As of 9/1/07, the Clinician-Directed Care Coordination Policy provides reimbursement for face-to-face and non-face-to-face care coordination for children in the Medicaid Program and CSHCN SP (See Attachment IV. C. NPM3). Policy utilization is being monitored.

The CSHCN SP has offered up to \$10,000 "seed funding" to Texas pediatric or family physician practices to apply practice-level Medical Home quality improvements in FY08 and FY09 http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=74328. One urban practice has enrolled to implement improvements during a six-month period in FY09. The Baylor College of Medicine Transition Clinic, a MHLC II participant, was funded by the Texas Council for Developmental Disabilities to provide additional support for youth with special health care needs in transition to adult health care and other community services. Over 200 health care professionals have completed the THSteps online medical home training module.

Activity 2: In the first half of FY08, 95% of CSHCN receiving case management and clinical services from CSHCN SP regional staff and contractors had a primary care provider (PCP). Of CSHCN with a PCP, 89% had seen their PCP in the past 12 months. Almost 500 CSHCN were assisted in establishing a medical home.

An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Provide leadership to, and collaborate with members of the MHWG to increase awareness and knowledge of the medical home concept and practice among all relevant audiences and to promote medical home services and quality improvements.

Output Measure(s): Progress on the MHWG strategic plan; progress on implementation of Medical Home Supports mini-grants; # of providers who complete the THSteps Introduction to Medical Home online module; review of Clinician Directed Care Coordination Policy implementation and utilization; articles published in the Provider Bulletin and Family Newsletter; presentation schedule (conferences, seminars, and other venues); website postings to primary websites - CSHCN Services Program website and Texas page of AAP medical home website, and other relevant websites; and development and dissemination of materials/tools information.

Monitoring: Review relevant newsletters, minutes, reports, staff activity documentation.

Activity 2: CSHCN Services Program regional staff and contractors help CSHCN link to medical homes.

Output Measure(s): Number and percent of CSHCN served by case management/clinical services contractors with a primary care physician (PCP) and who have seen their PCP in the past twelve months; number of CSHCN assisted with establishing a medical home by regional staff and case management/clinical services contractors; and contractor activities.

Monitoring: Review regional activity reports and contractor quarterly reports.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	52.9	52.9	52.9	54	54.1
Annual Indicator	52.9	52.9	52.9	52.9	58.2
Numerator	366173	366173	366173	366173	462528
Denominator	692198	692198	692198	692198	795137
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	58.3	58.4	58.5	58.6	58.7

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Activity 1: Pursue opportunities to collaborate with Texas Medicaid, CHIP, and other public/private health benefits providers and agencies to maximize health care coverage and quality assurance parameters of such coverage for CSHCN.

Update: During FY07, significant changes helped to maximize health care coverage for CSHCN. The Health and Human Services Commission (HHSC) awarded funding to community-based organizations to help families enroll in CHIP, Medicaid, and other services. An HHSC report, "Quality of Care in Medicaid Managed Care and CHIP in TX," noted that CSHCN have a higher representation in Texas public insurance programs (18-22%) than in the general population (12%). The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey measured 11 important domains. Families with CSHCN reported "usually" to "always" having positive experiences in eight to nine of the 11 domains. Scores for "getting care quickly" and "care coordination" were lower than other domains.

The 80th Texas Legislature provided \$707 million in general revenue (\$1.8 billion all funds) for the Frew lawsuit agreement to increase access to preventive services by Texas children with Medicaid. CSHCN SP staff solicited stakeholder input for the Advisory Committee established to prioritize the new funding. Medicaid payment rates for children for dentists, physicians, and specialists were increased. Plans were developed to increase CSHCN SP payment rates in FY08 and to review the impact of increased payment rates on the number of enrolled providers serving CSHCN. Staff also began work to improve client access in both Medicaid and the CSHCN SP by targeted activities to increase provider participation. Legislative changes were estimated to increase CHIP enrollment by 127,000 children.

The Legislature also provided additional funding to reduce CSHCN SP's waiting list, created the Health Opportunity Trust Fund to provide premium subsidies to individuals, and allowed for the development of tailored Medicaid benefits packages for CSHCN and other populations.

Activity 2: Maximize the provision of CSHCN Services Program health care benefits to eligible clients.

Update: DSHS regional staff and CSHCN SP contractors assisted families in accessing health insurance, including helping with CHIP/Medicaid/CSHCN SP enrollment/renewals to prevent lapses in coverage.

The CSHCN SP provided health care benefits for 2,222 CSHCN and assisted 54 families with insurance premium payment in FY07. During FY07, 143 children were released from the waiting list for CSHCN SP health care benefits, and 1,162 children on the waiting list received limited services for a 2-month period. Due to funding limitations, 1,447 children (700 with no other health care coverage) remained on the waiting list at the end of FY07.

Activity 3: Explore opportunities to enhance information shared with employers regarding the benefits and supports needed by employees who are parents of children with disabilities as well as the benefits and supports needed by employees with disabilities.

Update: The DSHS representative to the HB1230 Workgroup (enacted by the Texas 80th Legislature to improve employment opportunities and outcomes for youth with disabilities) provided experience and expertise in the transition issues related to CSHCN.

Activity 4: Provide information on public and private health insurance and financing of health care for CSHCN to families of CSHCN and providers.

Update: The CSHCN SP Client Handbook, in English and Spanish, was revised and disseminated through websites and print copies. The CSHCN SP Newsletter for Families included information on CSHCN SP and Medicaid health care benefits. CSHCN SP contractors participated in health fairs, coalitions, and other meetings to provide information on CSHCN SP benefits to families and community organizations.

Performance Assessment: In the 2005/06 NS-CSHCN, 58.2% of Texas CSHCN aged 0-18 reported having adequate private and/or public insurance to pay for needed services. While an improvement as compared to 2001 NS-CSHCN, Texas continues to fall below the national average of 62% noted in the 2005/06 NS-CSHCN. Additional analysis of survey data will continue. The CSHCN SP provided health care benefits to 12% more CSHCN in FY07 as compared to FY06.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pursue opportunities to collaborate with Texas Medicaid, CHIP, and other public/private health benefits providers and agencies to maximize health care coverage and quality assurance parameters of such coverage for CSHCN.				X
2. Maximize the provision of CSHCN Services Program health care benefits to eligible clients.	X	X	X	X
3. Explore opportunities to collaborate with employers and health plans regarding the benefits and supports needed for employees who are parents of children with disabilities and employees with disabilities.				X
4. Provide information on public and private health insurance and financing of health care for CSHCN to families of CSHCN and providers.			X	
5. Coordinate with Medicaid and CHIP to provide information for publication in their provider/family publications.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Texas Medicaid and CSHCN SP rates were raised to improve recruitment and retention of providers. HHSC submitted a concept paper to CMS outlining the state's Medicaid Reform plan through SB10, Texas 80th Legislature. HHSC is exploring a Health Opportunity Pool fund to provide premium subsidies to low-income adults and a tailored benefit package for CSHCN.

Activity 2: During the first half of FY08, 430 children were released from the waiting list for CSHCN SP health care benefits, a 200% increase as compared to FY07. Due to funding limitations, over 1300 children were on the waiting list for health care benefits as of 2/29/08. Of these children, 459 had no other health care coverage. The CSHCN SP assisted 43 families with insurance premium payment.

Activity 3: The CSHCN SP is tracking and will collaborate with SB10 Medicaid Reform activities that impact employer health plans, with particular attention to the proposed tailored benefits

package for CSHCN.

Activity 4: The CSHCN SP disseminated a new brochure and poster providing an overview of program benefits to regional offices, clinics, and contractors. CSHCN SP contractors participate in health fairs, coalitions and other meetings to provide information on benefits for families of CSHCN. The CSHCN SP responds to family phone and email inquiries about Medicaid, CHIP, and CSHCN SP benefits.

Activity 5: Changes to CHIP enrollment were published in the CSHCN SP Provider Bulletin.

c. Plan for the Coming Year

Activity 1: Pursue opportunities to collaborate with Texas Medicaid, CHIP, and other public/private health benefits providers and agencies to maximize health care coverage and quality assurance parameters of such coverage for CSHCN.

Output Measure(s): Documentation of collaborative initiatives/efforts with health care benefits providers and regulating agencies, e.g. collaboration regarding Medicaid Reform.

Monitoring: Documentation of progress made on collaborative efforts.

Activity 2: Maximize the provision of CSHCN Services Program health care benefits to eligible clients including: monitoring CSHCN Services Program health care benefits clients on the waiting list; payment of insurance premiums for clients on the CSHCN Services Program when needed to help families maintain cost effective private insurance; and an increase in CSHCN Services Program providers.

Output Measure(s): Number of CSHCN Services Program health care benefits clients by age and status (ongoing, received health care benefits, waiting list, waiting list with no other source of insurance, removed from waiting list); number of CSHCN Services Program health care benefits clients who received Insurance Premium Payment Assistance (IPPA); increase in the number of CSHCN Services Program providers.

Monitoring: Review monthly reports from Texas Medicaid and Healthcare Partnership and program quarterly reports.

Activity 3: Explore opportunities to collaborate with employers and health plans about benefits and supports needed for employees who are parents of children with disabilities and employees with disabilities.

Output Measure(s): Documentation of outreach activities and materials developed; information shared with employers and/or healthcare plan providers; feedback from employers and/or healthcare plan providers.

Monitoring: Documentation of progress made in sharing information with employers, the feedback and response to feedback; health plans requesting materials, response to trainings, meetings.

Activity 4: Provide information on public and private health insurance and financing of health care for CSHCN to families of CSHCN and providers and coordinate with Medicaid and CHIP to provide this information in their provider/family publications.

Output Measure(s): Articles published in CSHCN Services Program Family Newsletter and Provider Bulletins, and other publications, information posted on CSHCN Services Program website; informational materials shared via staff, contractors, or other means.

Monitoring: Review quarterly reports, agency action for implementing bill, articles published, and

pertinent articles published in Medicaid and CHIP publications.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	76.9	77	77.1	77.2	77.3
Annual Indicator	76.8	76.8	76.8	76.8	88.2
Numerator	193670	193670	193670	193670	706914
Denominator	252253	252253	252253	252253	801141
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	88.3	88.4	88.5	88.6	88.7

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. Numerator and denominator are weighted estimates.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Activity 1: Participate in DSHS collaboration with Texas Information and Referral / 2-1-1 system to foster effective linking of CSHCN and their families to community services and supports.

Update: In FY 07, there were over 123,000 Maternal and Child Health-related calls to the 2-1-1 system. The Health and Human Services Commission (HHSC) contracts with 25 Regional Area Information Centers to provide statewide information and referral services through the 2-1-1 system.

Activity 2: Participate in interagency and intra-agency efforts to assess and improve state policies and programs that impact CSHCN and their families.

Update: During FY07, CSHCN SP staff participated in the development and implementation of the Community Resource Coordination Group (CRCG) Interagency Memorandum of Understanding (MOU) to coordinate services to people with complex needs. The MOU was

signed by all five Health and Human Service agencies and other partner agencies (Texas Department of Criminal Justice, Texas Department of Housing and Community Affairs, Texas Education Agency, Texas Juvenile Probation Commission, Texas Workforce Commission, and the Texas Youth Commission (TYC)). CRCGs assisted in community placement for youthful offenders served by TYC. DSHS staff provided resources for CSHCN at the annual Operation Lone Star program which delivered free medical care to underserved communities in South Texas. CSHCN SP staff collaborates with Texas Parent to Parent who was awarded a Family to Family Health Information Center HRSA grant. The Department of Aging and Disability Services (DADS) received a grant from the Texas Council for Developmental Disabilities to identify autism service delivery innovations and to develop a resource guide of services available in Texas.

CSHCN SP staff participated in the Children's Policy Council whose report to the Legislature recommended the development of a coordinated independent case management system. In response to SB1188, the Health and Human Services Commission (HHSC) awarded a contract to study optimization of case management services. The CSHCN SP shared information to help orient the contractor and assisted in gathering data. The contractor recommended that Texas develop a "common" definition for case management across programs, guidelines for a tiered qualification for case managers, uniform screening protocols and reimbursement methodologies and integrated management information systems. CSHCN SP planned to work with HHSC as recommendations are reviewed and plans of action are developed.

Activity 3: Continue and enhance use of appropriate languages and cultural approaches in publications and other interactions with CSHCN Services Program consumers.

Update: The CSHCN SP published a bilingual booklet and bookmark to assist families of CSHCN in preparing for a disaster or emergency. The CSHCN SP Newsletter for Families included a bilingual Emergency Information Form. The booklet, bookmark, and the Emergency Information Form were shared through conferences, websites, and plans were established for future distribution through the DSHS statewide emergency preparedness campaign. The CSHCN SP reviewed contractor materials in languages other than English to assist with proficiency of translations. The CSHCN SP developed bilingual brochures and posters for families and CSHCN clients. The CSHCN SP Newsletter for Families, forms, brochures and documents were translated and made available online and in print.

Activity 4: Provide CSHCN case management through CSHCN Services Program.

Update: For FY07, 13,655 CSHCN received case management services from CSHCN SP contractors and DSHS regional staff. CSHCN SP contractors and DSHS staff participated in stakeholder meetings to assess and recommend improvements in policies and services for CSHCN. Staff assisted in addressing topics, such as medical home, transition, and cultural competencies.

Staff and contractors partnered with other community organizations to provide information, training, and resources to families of children with special health care needs and other community providers.

Performance Assessment: The 2005/06 NS-CSHCN indicated that 88.2% of families of CSHCN aged 0-18 reported that community-based services are organized so they can use them easily. This measure is not comparable across survey years due to changes in survey questions. Additional analysis of survey data will continue.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in DSHS collaboration with Texas Information and				X

Referral / 2-1-1 system to foster effective linking of CSHCN and their families to community services and supports.				
2. Participate in interagency and intra-agency efforts to assess and improve state policies and programs that impact CSHCN and their families.				X
3. Continue and enhance use of appropriate languages and cultural approaches in publications and other interactions with CSHCN Services Program consumers.			X	
4. Provide CSHCN case management through CSHCN Services Program.		X		
5. Enhance communication among CSHCN Services Program Contractors.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: For the first half of FY08, there were nearly 64,000 MCH-related calls to the 2-1-1 system. Title V and 2-1-1 staff continue to revise 2-1-1 data collection to provide more specific information. Updated information regarding CSHCN SP contractors was provided to 2-1-1.

Activity 2: CSHCN SP staff and contractors participated in numerous stakeholder meetings to assess and recommend improvements in policies and services for CSHCN. CSHCN SP staff was appointed to the Consumer Direction Workgroup and the HB1230 Workgroup on transition to employment. Staff participated in a statewide collaboration to strengthen early childhood comprehensive systems (Raising Texas) and in developing Children's Policy Council recommendations to the legislature. The CSHCN SP Newsletter for Families updated Contractor and regional contact information. Title V CSHCN Performance Measures were included in a unit-wide Quality Assurance Plan.

Activity 3: CSHCN SP staff began updating the bilingual Emergency & Disaster Planning for CSHCN Booklet (http://www.dshs.state.tx.us/cshcn/pdf/emerg_plan.pdf). CSHCN SP staff worked to ensure that contractors are able to communicate with clients in languages other than English.

Activity 4: In the first half of FY08, CSHCN SP contractors and regional staff provided case management services to 7,900 CSHCN.

Activity 5: CSHCN SP staff shared information with contractors about Champions "Organizing Services for Families" Forum. Quarterly conference calls continue.

c. Plan for the Coming Year

Activity 1: Collaborate with Texas Information and Referral / 2-1-1 system to foster effective linking of CSHCN and their families to community services and supports.

Output Measure(s): Quarterly Information and Referral / 2-1-1 data.

Monitoring: Review quarterly Information and Referral / 2-1-1 reports.

Activity 2: Participate in interagency and intra-agency efforts to assess and improve state policies and programs that impact CSHCN and their families.

Output Measure(s): Documentation of relevant groups in which CSHCN Services Program staff

participate actively; review of recommendations, policy, and program changes impacting CSHCN; contractor's record of discussion, recommendations, or actions at related committee/agency meetings related to performance measure.

Monitoring: Review and analyze Stakeholder Meeting Records and contractor quarterly reports.

Activity 3: Continue and enhance use of appropriate languages and cultural approaches in publications and other interactions with CSHCN Services Program consumers.

Output Measure(s): Bilingual publications and Spanish language content on CSHCN Services Program website; CSHCN Services Program staff/contractor training/discussions of experiences and lessons learned (informal and formal) with regard to cultural competency.

Monitoring: Review media, staff activities, contractor training, technical assistance, site observations, communications, and contractor quarterly reports.

Activity 4: Provide case management through CSHCN Services Program.

Output Measure(s): Number of CSHCN receiving case management from CSHCN Services Program contractors and regional staff.

Monitoring: Review contractor quarterly reports and quarterly regional activity reports.

Activity 5: Enhance and promote collaboration among CSHCN Services Program Contractors.

Output Measure: Discussion of contractor activities/successes and partnerships during contractor conference calls and internal communications.

Monitoring: Review contractor conference calls minutes, contractor and staff internal communication.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				5.8	5.8
Annual Indicator	5.8	5.8	5.8	5.8	37.1
Numerator					107424
Denominator					289879
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	37.2	37.3	37.4	37.5	37.6

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Numerator and denominator are weighted estimates.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Activity 1: Provide transition planning and referrals for CSHCN through case management services provided by CSHCN SP regional staff and contractors.

Update: DSHS regional staff and CSHCN SP contractors reported regular use of standardized transition letters and conducted transition planning with 1,120 CSHCN in FY07. Staff updated and translated web pages; wrote family and provider newsletter articles; wrote bi-lingual standardized permanency planning correspondence; participated in permanency planning training, attended and presented at statewide conferences, and sent many resource emails. Nearly 100 individuals completed the online case management transition training. Transition concepts were incorporated in the online adolescent health training module for Texas Health Steps (EPSDT) providers.

Activity 2: Work with selected CSHCN SP contractors and staff to provide transition services and report on best and promising practices.

Update: Contractors reported activities through conference calls and provided services via brochures, community workshops, high school/student interaction, parent/family future planning, and health provider access problem solving. Many of these activities included participation and collaboration with youth and parents and area education, rehabilitation, and other professionals.

Activity 3: Develop a mentoring initiative through which adults with special health care needs mentor transitioning youth with special health care needs.

Update: Staff were not able to recruit enough adults to gain statewide momentum. Originally conceived as a statewide, online mentoring initiative guided by a core group of young adults with disabilities, there are overriding concerns about technological applications, privacy, and security. A few local groups were identified. In lieu of a statewide mentoring initiative, staff developed plans to continue partnerships and seek more opportunities for involvement with youth and adults with special health care needs and their families to share information and advise the CSHCN SP about transition activities.

Activity 4: Recruit Transition Partners, including youth and adults with special health care needs, to advise the CSHCN SP about transition activities.

Update: CSHCN SP staff contacted Developmental Disabilities Council Leadership and Advocacy project leaders and exchanged information. Staff convened a planning committee including youth with special needs, and conducted a one-day Texas Teen Transition Expo for youth with special needs, in conjunction with the Annual Texas Parent to Parent Conference. Fourteen adolescents attended this first annual event.

Activity 5: Lead PHSU staff Transition Team to coordinate CSHCN SP transition activities.

Update: Bi-monthly meetings provided direction for program activities. The Team conducted a self-evaluation exercise to assess process and progress and began developing draft Family Resource Guide and Provider Resource Guide documents.

Activity 6: Collaborate with other entities to share information on transition planning and promising practices.

Update: Staff/contractors took part in the 2006 Leadership Education in Adolescent Health (LEAH) Conference and in 2007 LEAH Conference planning. CSHCN SP staff took part in the Texas Association on Higher Education and Disability (AHEAD) Conference, inter-agency meetings, and in writing Children's Policy Council legislative recommendations. CSHCN SP staff was appointed to the HHSC multi-agency work group for House Bill 1230, related to improving transition services, promoting inter-agency collaboration, and increasing opportunities for supported employment.

Performance Assessment: The 2005/06 NS-CSHCN indicated that, 37.1% of Texas youth with special health care needs receive services necessary to make a successful transition to adult life, falling below the national average of 41.2%. This measure is not comparable across survey years due to changes in survey questions. Additional analysis of survey data will continue. Work is ongoing to improve the effectiveness of case management support of transition from pediatric to adult health care service systems, to offer more information and training opportunities for families and case managers, and to participate in state-level arenas addressing transition to adult health care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide transition case management for CSHCN through CSHCN SP regional staff and contractors.		X		
2. Work with selected CSHCN SP contractors to provide transition services to CSHCN and to report on best and promising practices.				X
3. Partner with youth and adults with special health care needs and their families to share information and advise the CSHCN SP about transition activities.				X
4. Lead PHSU Transition Team to coordinate CSHCN SP transition activities.				X
5. Share resources and collaborate on transition planning and promising practices.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Through the 2nd quarter of FY08, regional staff/contractors have provided transition planning for over 400 CSHCN. Support activities include updated web pages, newsletters, participation in statewide conferences, staff training, and shared resources.

Activity 2: Contractors report in conference calls and provide services via brochures, local

workshops, high school/student interaction, parent/family future planning, and health provider access problem solving. Some contractors began participating in the CSHCN SP Transition Team meetings.

Activity 3: Staff presented at a statewide transition conference and met with youth to plan the 2008 Teen Transition Expo (see attachment).

Activity 4: Bi-monthly meetings exchanged information, including information about housing and homelessness among youth, and provided direction for program operations.

Activity 5: CSHCN SP staff participated in HHSC's Transition and Supported Employment Work Group writing multi-agency recommendations; prepared "at-a-glance" tools for Medicaid waiver and non-waiver community-based services; provided comment to add health into the National Secondary Transition Technical Assistance Center Transition Toolkit; made presentations; and presented a curriculum teaching clients of centers for independent living. Texas Department of Assistive and Rehabilitative Services received a Medicaid Infrastructure Grant to improve competitive employment supports for people (including youth) with disabilities.

An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Provide transition case management for CSHCN through CSHCN SP regional staff and contractors.

Output Measure(s): Resources provided to CSHCN SP Regional staff/contractors regarding transition; utilization of online or other transition training for case managers; number of CSHCN receiving individual transition services from CSHCN SP contractors and regional staff.

Monitoring: Review transition training data and quarterly regional and contractor case management reports.

Activity 2: Work with selected CSHCN SP contractors and staff to provide transition services and report on best and promising practices.

Output Measure(s): Contacts with contractors to discuss transition activities, exchange information, and provide technical assistance to promote identification and reporting of successful practices.

Monitoring: Review contractor quarterly reports, information exchanged, conference calls, and staff summaries.

Activity 3: Partner with youth and adults with special health care needs and their families to share information and advise the CSHCN SP about transition activities.

Output Measure(s): Youth, adult, and family advisors identified and input/guidance received on transition activities.

Monitoring: Review progress reports.

Activity 4: Lead PHSU Transition Team to coordinate CSHCN SP transition activities.

Output Measure(s): Progress reports - Transition Team activities, products, and results.

Monitoring: Review meeting minutes, publications, and progress reports.

Activity 5: Share resources, develop trainings, and collaborate on transition planning and

promising practices.

Output Measure(s): Distribution of and updates to Family Resource Guide; utilization and updates to CSHCN SP web site transition page; information shared with CSHCN, families, providers, and others via publications/presentations; information reported at and outcomes or results from meetings attended; participation in planning and attendance at LEAH Transition and other conferences; reports on participation in interagency and other workgroups to collaborate with transition planning processes, services, information-sharing, etc.

Monitoring: Review resource information shared, trainings developed, meeting minutes, stakeholder meeting records, and reports of other collaboration efforts.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	80	80	80	80	80
Annual Indicator	77.2	72.5	78.4	76.7	76.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	80	80	80	80	80

Notes - 2007

Source for these data is the National Immunization Survey http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0607.htm (accessed on 06/15/2008). Data for 2007 is based on preliminary data from the time period of July 2006 to June 2007.

Notes - 2006

Source for these data is the National Immunization Survey - 2006. http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2006.htm(accessed on 06/15/2008).

Notes - 2005

Source for these data is the National Immunization Survey - 2005. http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2005.htm(accessed on 06/15/2008).

a. Last Year's Accomplishments

Activity 1: Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.

Update: The Texas Stakeholders Immunization Working Group (TISWG) is a statewide collaboration entering into its fourth year. It has maintained its original membership with the added members from Meningitis Angels, Texas Higher Education Coordinating Board and the

Novartis Pharmaceutical Group. TISWG has met three times in FY07: November, March, and August. The partnership goal to raise vaccination coverage levels across the state through promotion of the nationally known best practices continues.

Of the 50 local health department affiliates of DSHS reviewed in FY 2007, 11 reported successes in creating and sustaining partnerships. Twenty-two facilities reported outreach and networking efforts, however there was no indication of partnership development, towards collaborative efforts to raise vaccine coverage levels. Seventeen had a minimal number of identified partners with no efforts or evidence in developing working relationships needed to raise vaccination coverage levels

Activity 2: Through provider and birth registrar education, training and technical assistance, promote the use of the state immunization registry, ImmTrac.

Update: Statewide, 393,887 children under the age of six (6) years were added to ImmTrac during FY07.

Activity 3: Identify birth and delivery characteristics that are associated with not being immunized.

Update: Birth record data are routinely matched to the ImmTrac. After discussions with staff responsible for ImmTrac, it was determined that the ImmTrac registry data is not sufficient to provide reliable information that could be analyzed and used for program planning. A continuing relationship with ImmTrac staff will ensure that these analyses will be completed when ImmTrac is more thoroughly populated. Immunization staff were invited to join SSDI Governance Committee to facilitate data linkages in the future.

Performance Assessment: After reaching a high of 78.4% in 2005, the immunization rate declined 2% between 2005 and 2006 and experienced another decline, though small, between 2006 and 2007. Continued activities include, but are not limited to, statewide distribution of vaccines, promotion of ImmTrac registration, well-checks provided through Title V contractors, provision of training and technical assistance, and the development and support of partnerships that can educate providers and promote adherence to immunization schedules in local areas.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.				X
2. Through provider and birth registrar education, training and technical assistance, promote the use of the state immunization registry, ImmTrac.			X	
3. Explore opportunities to link existing administrative data sets within DSHS and across HHSC and other state agencies.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Texas Immunization Stakeholder Working Group TISWG continues to be a lead resource for active partnerships within the immunization branch. Now entering its fourth year since inception, TISWG has retained its original core member base and continues to add quarterly. TISWG has met in November 2007, and February 2008. During the November meeting, TISWG established three high priority best practice goals including: Influenza Immunization Awareness, Increasing 4th DTaP Coverage, and Improving Adolescent Vaccination. Work will continue in 2008 to develop and implement plans to meet these goals.

Activity 2: There were 202,069 children under six years of age added to ImmTrac from September 1, 2007, through February 29, 2008. A total of 2,161,391 children participated in ImmTrac during the first two quarters of FY08.

Activity 3: Current ImmTrac data are matched to the birth certificate file. However, the ImmTrac data are incomplete and not available for analysis. Working with staff responsible for immunization and the SSDI governance committee, other opportunities may be identified for linking.

c. Plan for the Coming Year

Activity 1: Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.

Output Measure(s): Number and types of partnerships; summary report on efforts undertaken; current initiatives and outcomes or expectations.

Monitoring: Track the number and type of partnership activities.

Activity 2: Through provider and public training, technical assistance and education, promote the use of the state immunization registry, ImmTrac and the Vaccines for Children program.

Output Measure(s): Number of children under six who participate in the state immunization registry, ImmTrac; Number and types of training conducted; and number of new providers added to the Vaccines for Children program.

Monitoring: Track number of new children entered into the ImmTrac system and number of providers added to the Vaccines for Children program.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	50	50	37	37	37
Annual Indicator	37.0	37.9	35.3	33.7	33.6
Numerator	18271	18588	18092	17920	17757
Denominator	493945	490212	513133	531239	528403
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	32	32	31	31	30

Notes - 2007

Data presents a projected linear trend for 2006 and 2007 based on vital statistics data from 2001 through 2005. Data from 2005 are preliminary.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

Notes - 2006

Data presents a projected linear trend for 2006 and 2007 based on vital statistics data from 2001 through 2005. Data from 2005 are preliminary.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

Notes - 2005

Data from 2005 vital statistics are preliminary.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

a. Last Year's Accomplishments

Activity 1: Make available funds through competitive RFPs for the provision of family planning services statewide.

Update: Seventy-six DSHS contractors provided family planning services to 18,027 teens ages 15-17. Of these, 17,310 were female and 717 were male. The services were provided through a combination of Title V, X, and XX family planning funds. Due to contractor attrition in the last two quarters of FY07, the number of contractors dropped from 97 in February 2007 to 83 in August.

Activity 2: Provide funding for community-based abstinence projects for adolescents and teenagers.

Update: The Abstinence Education Project served 227,461 unduplicated clients for FY07 through 33 community-based contractors and 20 School Health Education Service Center contractors that provided abstinence education services. Interruptions in federal legislation and funding during the end of the fiscal year, as well as the loss of three large community based contractors, negatively impacted the total number of clients served.

Activity 3: Identify target areas and subpopulations in the state with highest rates of teen pregnancy and repeat teen pregnancies and provide funds through a population-based competitive RFP to address teen pregnancy in the targeted areas.

Update: In FY07, a continuation RFP was released to support awards made in FY06 to address teen pregnancy, STDs, adequacy of prenatal care and low birth weight. Sixteen awards were made with five of these contracts specifically addressed teen pregnancy. The evidence-based curriculum used in these projects included Reducing the Risk, Becoming a Responsible Teen, Future Orientation, Voices/Voces, Reducing the Risk, Baby Think it Over, and Plain Talk/Hablo Claro. A roster of all contractors and their topic areas is included in Attachment IV.C. NPM8.

Activity 4: Provide information to contractors, regional staff and other stakeholders to increase awareness of teen pregnancy rates, including the disparity in the rates for Hispanic and African

American teens.

Update: The Title V staff hosted the Hispanic Teen Pregnancy Prevention Summit in October 2007. The objective was to convene a multi-disciplinary group of public health policy makers, researchers, clinicians, and social scientists, to identify the unique components necessary for an effective pregnancy prevention program for Hispanic youth. Title V staff invited representatives from local, state, and national organizations and developed the agenda for the day and a half event. Several presentations on adolescent pregnancy were also prepared in FY07 for presentation in FY08.

Activity 5: Conduct a Perinatal Periods of Risk (PPOR) analysis of most recent available data for Texas.

Update: Data from 1999 through 2003 were analyzed using the PPOR analytic framework. Findings were presented at various locations around the state.

Activity 6: Analyze PRAMS unintended pregnancy data and develop a policy paper that includes recommended best practices and interventions for specific populations.

Update: Analysis of pregnancy timing has been completed. Findings presented to the March of Dimes' Program Services Committee included the benefits of folic acid and preconception health, and impact of stress in African-American pregnancies.

Activity 7: Explore collaborations with Baylor University School of Medicine, Division of Adolescent Health to develop and test innovative solutions to reduce teen pregnancy.

Update: The relationship with Baylor University School of Medicine, Division of Adolescent Health and Title V led to the DSHS Adolescent Health and Child Health Coordinators attending five LEAH conferences at Baylor. While general, these trainings have led to the development of better and more complete ideas about interventions to reduce adolescent pregnancy.

Performance Assessment: While projections suggest continued declines in 2006 and 2007, national data for 2006 suggest an increase in adolescent birth rates. Texas also continues to have one of the highest adolescent birth rates in the country. Efforts to reduce adolescent pregnancy will continue to utilize a comprehensive, community-based approach that includes family planning services. Texas Title V has also conducted analyses to understand how changing Texas demographics will impact adolescent pregnancy. These analyses have helped to focus future strategic directions and identify the need for culturally tailored prevention messages and interventions.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Make available funds through continuation request for proposals (RFPs) for the provision of family planning services statewide.	X			
2. Identify target areas and subpopulations with highest rates of teen pregnancy and repeat teen pregnancies and provide Title V funds through a population-based RFP to address teen pregnancy in the targeted areas.			X	
3. Provide information to contractors, regional staff and other stakeholders to increase awareness of teen pregnancy rates, including the disparity in the rates for Hispanic and African American teens.				X

4. Engage external and internal stakeholders to identify opportunities and innovative interventions to prevent adolescent pregnancy.				X
5. Analyze PRAMS unintended pregnancy data and develop a policy paper that includes recommended best practices and interventions for specific populations.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Number of Family Planning Contractors: Title V-48, Title X-50, Title XX-67. 8,620 clients aged 15-17 were served by contractors.

Activity 2: There are sixteen total contracts in the Population-Based Program. Of these, eight are in their last year. Six of these projects address teen pregnancy with three concluding at the end of FY08. Final reports are due at the end of the projects. Curriculum used in these six projects includes abstinence only, abstinence plus, and comprehensive approaches that include Making Proud Choices, Worth the Wait, Big Decisions, Becoming a Responsible Teen, Voices/Voces, and No Way Baby.

Activity 3: Staff from DSHS' Family Planning Program and the Office of Title V met in December to discuss Teen Pregnancy Fact Sheets. Agreement was reached to have the Office of Title V develop data sheets. A workgroup was convened to discuss teen pregnancy prevention strategies.

Activity 4: In October 2007, Title V staff hosted the Hispanic Teen Pregnancy Summit with 40 participants from 6 national, 13 state, and 4 local agencies. Post-Summit meetings have been held to identify key next steps. Title V Staff are in the process of collaborating with the University of Texas to facilitate teen focus groups to guide future teen pregnancy prevention activities. In preparation for these activities, Title V is currently developing a Hispanic Adolescent Pregnancy Prevention Initiative Steering Committee.

Activity 5: Report of FY04 data is in development.

c. Plan for the Coming Year

Activity 1: Increase opportunities to engage in teen pregnancy prevention activities at the state and local levels.

Output Measure(s): Number of procurement opportunities for teen pregnancy prevention service provision, Number of Title V contractors, number of Title X contractors; the number of Title XX contractors; the number of teens receiving family planning services; number of teens served through Health Service Region activities; number of teens served through abstinence activities.

Monitoring: Review contractor quarterly and annual reports for number of clients served.

Activity 2: Coordinate educational and awareness activities to increase understanding of teen pregnancy prevention, including disparities (racial/ethnic, geographic) in rates.

Output Measures: Number, type and format of activities implemented.

Monitoring: Copy of materials or products distributed; summary of annual events.

Activity 3: Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent adolescent pregnancy.

Output Measures: Number of meetings and types of partners engaged; developed proposals for implementation; implemented activities.

Monitoring: Review meeting notes; quarterly progress reports.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	21	22	35	35	35
Annual Indicator	43.4	54.3	22.7	22.7	22.7
Numerator	1550	6468	67705	71225	72898
Denominator	3572	11902	298260	313768	321135
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	34.4	34.4	34.4	35	35

Notes - 2007

The DSHS 2004-2006 Statewide Basic Screening Survey was used to estimate the percent of 3rd graders who received sealants. This percent was then applied to number of 3rd graders in Texas for 2007 (source: Texas Education Agency; <http://www.tea.state.tx.us/student.assessment/reporting/>).

Notes - 2006

The DSHS 2004-2006 Statewide Basic Screening Survey was used to estimate the percent of 3rd graders who received sealants. This percent was then applied to number of 3rd graders in Texas for 2006 (source: Texas Education Agency; <http://www.tea.state.tx.us/student.assessment/reporting/>).

Notes - 2005

The DSHS 2004-2006 Statewide Basic Screening Survey was used to estimate the percent of 3rd graders who received sealants. This percent was then applied to number of 3rd graders in Texas for 2005 (source: Texas Education Agency; <http://www.tea.state.tx.us/student.assessment/reporting/>).

a. Last Year's Accomplishments

Activity 1: Continue providing dental sealants to Texas third grade population statewide.

Update: From September 2006 through August 2007, 6,047 third graders who were eligible for program services received dental sealants through the direct efforts of the DSHS regional dental teams or through collaborations between DSHS regional dental teams and community-based and/or dental academic-based affiliations.

Activity 2: Continue to establish baseline data on the numbers of 3rd graders with untreated caries to gather data to use in guiding programmatic decisions.

Update: Basic Screening Survey (BSS) data were collected during FY05 and FY06 for a statistically valid sampling of third grade students in Texas who attended public elementary schools that had a 50% or higher free or reduced lunch population. The FY05/06 BSS data indicates that 23% of the third grade population sampled has received protective sealants on at least one permanent molar tooth. The BSS data analyses were used to create baseline data for third graders with untreated caries. The data have shown a higher prevalence of untreated dental decay in third graders who are on free and/or reduced lunch who are not receiving Medicaid benefits. The data also show differences in caries prevalence between rural, urban, and border settings in Texas. The data will be utilized to support programmatic funding requests during the 2009 legislative session.

Performance Assessment: The proportion of third grade children who have received protective sealants for 2005, 2006, and 2007 was reported using the Texas BSS collected during the 2004-2005 academic year. This initial BSS was representative of only schools with a student population with 50% or more receiving free or reduced school lunch. Since the initial data collection, dental services that had been eliminated from the Children's Health Insurance Program during a previous legislative session were restored, Medicaid reimbursement rates have increased, and programs, such as the First Dental Home Initiative, have been implemented. The impact of these initiatives can be assessed in 2008 with the reporting of a newly collected BSS that is representative of all 3rd grade students in Texas.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue providing dental sealants to Texas third grade population statewide.	X			
2. Continue to monitor data on the numbers of third graders with untreated caries to use in guiding programmatic decisions.				X
3. Track number of children receiving dental care through Medicaid and Children's Health Insurance Program (CHIP) to use in guiding programmatic decisions.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: During FY2008 first and second quarters, the DSHS Oral Health Program (OHP) regional dental teams continued to provide dental sealants to program eligible children. The eligible children include third grade and other grades within the elementary schools that participated in the sealant program. DSHS OHP staff continue to collaborate with various partners in an effort to expand the provision of dental sealants to eligible children.

Activity 2: DSHS OHP regional dental teams continue to conduct the Basic Screening Survey (BSS), collecting data on a statistically valid sample of third grade students in Texas. The BSS survey data will be included in an Oral Health of Texas chartbook to be used by internal and external stakeholders.

Activity 3: Title V staff continue to work with HHSC to obtain the data on the number of Texas children participating in CHIP who receive dental services during FY08. Final claim data for these services has a six to eight month delay from the actual date of service.

c. Plan for the Coming Year

Activity 1: Continue providing dental sealants to Texas third grade population statewide.

Output Measure(s): Number of third graders who receive dental sealants.

Monitoring: Track progress of the data collection, analysis and reporting.

Activity 2: Continue to monitor data on the numbers of third graders with untreated caries to use in guiding programmatic decisions.

Output Measure(s): Summary (race, geography, etc.) of convenience and/or statistical sampling data from regional dentists and other entities.

Monitoring: Analyze, interpret and report on data collected.

Activity 3: Track number of children receiving dental care through Medicaid and Children's Health Insurance Program (CHIP) to use in guiding programmatic decisions.

Output Measure: Summary of service utilization.

Monitoring: Analyze, interpret and report on data collected.

Activity 4: Collaborate with multiple stakeholders to develop activities and materials to promote the use of dental sealants to both providers and recipients of services.

Output Measure: Number and type of stakeholders involved in developing activities, number of meetings held, and number and type of tangible products developed.

Monitoring: Documentation of meetings held and brochures, posters and other materials developed and distributed.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5.5	5.5	5.5	5.4	5.1
Annual Indicator	5.4	6.2	4.5	4.9	4.8
Numerator	259	296	234	257	254
Denominator	4752653	4768628	5185439	5287340	5294277
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	4.7	4.7	4.6	4.6	4.5

Notes - 2007

Data presents a projected linear trend for 2006 and 2007 based on vital statistics data from 2000 through 2005. Data from 2005 are preliminary.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

Notes - 2006

Data presents a projected linear trend for 2006 and 2007 based on vital statistics data from 2000 through 2005. Data from 2005 are preliminary.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

Notes - 2005

Data from 2005 vital statistics are preliminary.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>). The large change in population estimates from 2004 to 2005 is because prior to 2005, the denominator only included children aged 1-14 years. Trends were calculated using appropriate denominators.

a. Last Year's Accomplishments

Activity 1: Conduct traffic safety presentations throughout the state.

Update: Safe Riders conducted 29 traffic safety presentations to 603 persons. This included two presentations to teen parents (or parents-to-be), 16 presentations to elementary school classes in Round Rock and Pflugerville, and 12 presentations to adults groups that included teen parents (or parents-to-be), and four presentations to adult audiences: a firefighter's regional conference, a mom's club, a home for low-income mothers, parent-teacher associations, and an association of child care providers.

Activity 2: Distribute car safety seats to low-income families throughout the state and train recipients on the proper use of the seats.

Update: Safe Riders monitored 99 community programs statewide as they operated a child seat distribution program. To receive a seat, a family or parent is required to attend a one-hour class regarding child passenger safety. An average of 153 such classes is conducted each month by Safe Riders' 99 local program partners, resulting in 918 classes conducted for the reporting period. Safe Riders distribution program partners distributed 8,842 seats in conjunction with education programs. Safe Riders also sent 3,171 child seats to the following five agencies for distribution to low-income families in conjunction with child seat checkup events: Texas Cooperative Extension, Hillcrest Health System (Waco), Dallas County Hospital, Texans in Motion (Austin), and Texas Children's Hospital (Houston).

Activity 3: Assess the need for training middle school-aged children in the state on the dangers of riding with alcohol-impaired drivers; and, if appropriate, select or identify a training module to deliver.

Update: Although Safe Riders is not funded to research or conduct traffic safety interventions with middle-school-aged children, some explorations into this area were made. This included contacting national Think First!, an injury-prevention program of coalitions with specific programs

aimed at children in elementary schools (Think First Kids), tweens (Think First Youth) and teens (Think First Teens).

Activity 4: Review of report on child deaths resulting from motor vehicle accidents in the state and develop policy recommendations aimed at reducing such deaths, as appropriate.

Update: Safe Riders conducted training workshops in Baytown, McAllen, and Marble Falls as these were locations identified during the review of child deaths and injuries from motor vehicle crashes. The State Child Fatality Review Team (SCFRT) Committee issued the Annual Child Fatality Review Team Report, which identified motor vehicle crashes as a leading cause of child death in Texas. To strengthen understanding and access to resources needed in this area, representatives from Texas Department of Public Safety and from Texas Department of Transportation became permanent members of the SCFRT as a result of action in the 80th Texas Legislative Session.

Performance Assessment: Though provisional, the mortality rate due to motor vehicle crashes among children 14 years of age and younger declined in 2005 to under 5.0 deaths per 1,000 children. Projections suggest that this rate will remain under 5.0 in 2006 and 2007. Future activities need to emphasize continued prevention to lower the number of annual deaths. Increased collaboration between the SCFRT and local CFRTs, and the Texas Department of Transportation will help to identify and meet educational needs and prevention opportunities. Texas continues its commitment to provide education and child safety seats throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct traffic safety presentations throughout the state.			X	
2. Distribute car safety seats to low-income families throughout the state and train recipients on the proper use of the seats.			X	
3. Review of report on child deaths resulting from motor vehicle accidents in the state and develop policy recommendations aimed at reducing such deaths, as appropriate.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Fifteen traffic safety presentations were conducted in five different Texas communities. Audiences included parents (including teen and foster), social service, child care workers, and other adults. A total of 183 adults were trained and 165 children attended traffic safety presentations, including 100 Cub Scouts attending a 5-safety station merit badge event.

Activity 2: DSHS Safe Riders program has 99 Texas community distribution partners, all of which have been trained and equipped to conduct classes and distribute child safety seats to low-income families. Staff conducted 1,228 hour-long classes and distributed 5,026 seats. The program also provided 2,201 child safety seats to community programs for distribution during car seat check events conducted by certified child passenger safety technicians.

Activity 3: Child Fatality Review Teams activities included conducting car safety seat clinics in

their communities and distributing information about safety of children in and around cars. In preparing the FY2007 Child Fatality Review Annual Report, the State Child Fatality Review Team Committee recommended that the Texas Department of Transportation develop and adopt an education campaign to reduce young child injury and death from roll-overs and back-overs.

c. Plan for the Coming Year

Activity 1: Distribute child safety seats to low-income families via educational classes throughout the state.

Output Measure(s): Number of organizations that participate in the distribution and education program; the number of safety seats issued to participating organizations; and the number of safety seats distributed.

Monitoring: Maintain a current list of participating organizations; track the number of seats distributed to the organizations on an ongoing basis.

Activity 2: Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.

Output Measure(s): Number of CPS technician training courses per quarter; number of students per course; number of update/renewal classes for certified CPS technicians; and number of students per update/renewal classes.

Monitoring: Track number of technician training courses (per calendar year); number of students per course; number of update/renewal classes per year; number of students per class.

Activity 3: Conduct traffic safety presentations throughout the state.

Output Measure(s): Number of traffic safety presentations conducted; number of persons attending each presentation.

Monitoring: Track progress of presentations conducted (per calendar year).

Activity 4: Review of report on child deaths resulting from motor vehicle crashes and develop policy recommendations and activities aimed at reducing such deaths.

Output Measure(s): Annual Child Fatality Review Team Report on child deaths that includes motor vehicle crash deaths and policy recommendations; development of State CFRT Committee on Prevention to collect local CFRT recommendations and prevention activities; training session(s) on reducing motor vehicle crash deaths and appropriate prevention strategies at CFRT Annual Conference.

Monitoring: Updates on child deaths, prevention and training activities, and potential recommendations at quarterly State Child Fatality Review Team Committee meetings.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
---------------------------------------	------	------	------	------	------

Annual Performance Objective				38	38.5
Annual Indicator			37.5	34.9	34.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	37	37.5	38	38.5	39

Notes - 2007

Source of data is the National Immunization Survey. Numerator and denominator data are not available.

The CDC has changed how breastfeeding rates are presented from last year. Previously, results were presented by the year the mother was surveyed. Results are now presented by birth year and 2004 is the most recent year available.

Data presents a projected linear trend for 2005 through 2007 based on updated birthyear data from 2001 through 2004. The final percentages for previous years were:

- Year 2001 - 38.8
- Year 2002 - 38.8
- Year 2003 - 35.5
- Year 2004 - 37.3

Notes - 2006

Source of data is the National Immunization Survey. Numerator and denominator data are not available.

The CDC has changed how breastfeeding rates are presented from last year. Previously, results were presented by the year the mother was surveyed. Results are now presented by birth year and 2004 is the most recent year available.

Data presents a projected linear trend for 2005 through 2007 based on updated birthyear data from 2001 through 2004. The final percentages for previous years were:

- Year 2001 - 38.8
- Year 2002 - 38.8
- Year 2003 - 35.5
- Year 2004 - 37.3

Notes - 2005

Source for data is 2004 National Immunization Survey. Numerator and denominator data are not available.

a. Last Year's Accomplishments

Activity 1: Monitor breastfeeding rates of mothers.

Update: The Title V program considered several different data sources to gain an understanding of breastfeeding initiation rates for the state. In 2007, 70.8% of women receiving WIC services while pregnant attempted to breastfeed. As reported in the National Immunization Survey, this

rate is slightly lower than reported in the general population (75%). Other data points that are monitored using the National Immunization Survey include breastfeeding at 6 and 12 months (37.3%; 18.7%) and exclusive breastfeeding at 3 and 6 months (25.2%; 7.1%). The 2007 WIC Infant Feeding Practices Survey also assesses breastfeeding rates in the WIC population. Data entry began and will continue through FY08. Another source of breastfeeding surveillance data is the analyses of the annual WIC Infant Feeding and Practices Survey. Findings from this survey are posted to the DSHS website (<http://www.dshs.state.tx.us/wichd/nut/pdf/InfantFeedingPracticesSurvey.pdf>).

Activity 2: Improve community access to education and support resources to promote breastfeeding by providing multiple venues.

Update: WIC held two train-the-trainer peer counseling trainings with approximately four participants and a Peer Counselor Workshop with twenty-four persons (made up of WIC directors, breastfeeding coordinators, lactation consultants, hospital nurses and others who were interested in establishing Peer Counselor Programs and training peer counselors). The Web Status report for FY '07 indicates 50,124 hits were made to the Lactate section of the WIC website. A DSHS representative was present at all five Texas Breastfeeding Coalition meetings that occurred in FY '07.

Activity 3: Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps (TTS).

Update: Nine applications to receive the Texas Ten Steps certification were received from hospitals and five applications were approved. A list of accredited hospitals can be found at <http://www.dshs.state.tx.us/wichd/lactate/TXfact.shtm>.

Activity 4: Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

Update: For FY07, there were 69 Mini I Breastfeeding Workshops with a total of 1,514 participants and 34 Mini II Breastfeeding Workshops with 602 participants. The one-day workshops are designed for health care professionals and others to support patients' efforts to breastfeed. In addition, there were five Principles of Lactation Management (POLM) classes with a total of 279 participants and six Lactation Counseling and Problem Solving (LCAPS) class with a total of 135 participants. Participants have included physicians, nurses, nutritionists and others.

Activity 5: Assist Texas worksites to become designated through the Mother Friendly Worksite Program (MFWP) and provide follow-up support.

Update: In an effort to assist Texas worksites in becoming designated as MFWP and for the provision of follow-up, sample policies are posted on the website, all support materials are available through the website. Thirteen applications for MFWP designation were received and five were approved.

Activity 6: Assist WIC in the development and implementation of an in-depth breastfeeding survey.

Update: Previous versions of the WIC Infant Feeding Practices survey were reviewed. A new survey was developed, received Institutional Review Board (IRB) approval, and was implemented. Approximately 6,000 WIC clients completed the survey in English or Spanish. Data entry began and will continue through FY08.

Performance Assessment: There has been a downward trend in the percent of mothers who breastfeed their infants at 6 months of age. Meeting this performance objective will require the

continued creation of social environments that support the initiation and practice of breastfeeding. Future activities will focus on promoting breastfeeding friendly hospital policies, continued expansion of mother-friendly worksites, and the continued analyses of state-level data to identify opportunities in need of breastfeeding support and intervention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve community access to education and support resources to promote breastfeeding by providing multiple venues.				
2. Assist Texas hospitals and birthing centers (birthing facilities) to become accredited through Texas Ten Steps.				
3. Provide breastfeeding training and resources to health care professionals, including race and ethnicity, by using multiple methods, including distribution of educational materials and conducting training programs.				
4. Assist Texas worksites to become designated through the MFWP and provide follow-up support.				
5. Assist WIC in the annual development, implementation, and analysis of an in-depth breastfeeding survey.				
6. Monitor breastfeeding rates of mothers.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The average number of visits to the website for breastfeeding information averaged 7,064 visits per month ranging from 5,196 visits in October to 8,867 visits in January. Title V staff have attended three meetings of the Texas Breastfeeding Coalition.

Activity 2: Four birthing facilities were accredited as Texas Ten Step sites. Seven applications were received. Ten birthing facilities are designated mother friendly out of the 63 total Texas Ten Step sites.

Activity 3: There were 64 trainings offered reaching 924 nurses, 32 physicians, and 36 dietitians. Four hundred sixty one persons were white, 48 were black, 149 were Hispanic, 48 were Asian, 1 was Native American and 572 were unknown. The Texas WIC program is developing trainings on supporting breastfeeding when challenges occur to be offered at physician conferences.

Activity 4: Thirty-three sites were designated as mother-friendly during the first two quarters of FY08 for a total of 195 worksites.

Activity 5: A report describing WIC mothers' attitudes and barriers to breastfeeding was developed using the data collected as part of the 2006 WIC Infant Feeding Practices Survey. Data for the 2007 WIC Infant Feeding Practices Survey have been entered and cleaned. Meetings have occurred to begin to develop the analysis plan.

Activity 6: In the WIC population, breastfeeding initiation averaged 71.6% per month. Variation between months was less than half of a percentage point. Breastfeeding at 6 months was 45%.

c. Plan for the Coming Year

Activity 1: Improve community access to education and support resources to promote breastfeeding.

Output Measure: Number of new WIC breastfeeding peer counselors trained; number of WIC and non- WIC participants attending training; number of hits to website; number/type of breastfeeding promotion materials produced; number of Texas Breastfeeding Coalition meetings attended; number/type of breastfeeding promotion activities initiated by DSHS.

Monitoring: Review quarterly progress reports from WIC website; review training participants' attendance forms; review materials; review meeting rosters and notes.

Activity 2: Assist Texas hospitals and birthing centers (birthing facilities) to become accredited through Texas Ten Steps and evaluate breastfeeding rates at hospitals that have been accredited.

Output Measure: Number of application packets received; number of birthing facilities accredited; number/type of technical assistance (TA) contacts made; number of birthing facilities that are Mother-Friendly Worksite Program (MFWP) applicants. Evaluation report comparing hospitals that are Texas Ten Steps certified to hospitals that are not.

Monitoring: Track progress in providing training and TA as requested and follow up with the accreditation process. Track quarterly progress on the development of the study, data analysis, and report writing.

Activity 3: Provide breastfeeding training and resources to health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

Output Measure(s): Number of training sessions provided; number of health care professionals participating in training by race and ethnicity; report on the number and type of strategies developed to involve physicians in breastfeeding promotion; number of hits on Resources for Physicians website.

Monitoring: Track progress in providing training and technical assistance as requested; document training schedule and attendance.

Activity 4: Assist Texas worksites to become designated through the MFWP and provide follow-up support.

Output Measure(s): Maintain policies posted on website; number of MFWP materials distributed; database of designees developed; number/type of TA contacts; number of new worksites.

Monitoring: Track progress in increasing the number of worksites designated and completing the MFWP evaluation.

Activity 5: Monitor breastfeeding rates of mothers through the analysis of previously collected breastfeeding surveillance data (WIC annual Infant Feeding Practices Survey, PRAMS, Texas BRFSS).

Output Measure: Percent of mothers who initiate breastfeeding prior to hospital discharge; percent breastfeeding at six months; written review of data; data review communicated to external stakeholders including March of Dimes, Health Start, WIC, and Title V fee-for-service and population-based providers.

Monitoring: Review quarterly WIC data, and birth record, PRAMS, and National Immunization Survey data as available.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	92	92	90	90	92
Annual Indicator	82.1	89.2	89.6	90.8	95.0
Numerator	309701	340427	345394	357595	379344
Denominator	377374	381441	385580	393922	399107
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	96	96.2	96.3	96.4	96.5

Notes - 2007

Source for the numerator is the Texas Department of State Health Services Newborn Hearing Screening Database. The denominator is a projection of total live births using vital statistics data from 1991 to 2005. Data from 2005 vital statistics are preliminary.

Notes - 2006

Source for the numerator is the Texas Department of State Health Services Newborn Hearing Screening Database. The denominator is a projection of total live births using vital statistics data from 1991 to 2005. Data from 2005 vital statistics are preliminary.

Notes - 2005

Source for the numerator is the Texas Department of State Health Services Newborn Hearing Screening Database. The denominator is the estimated number of total live births using preliminary 2005 vital statistics data.

a. Last Year's Accomplishments

Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data from the tracking system established to manage the program.

Update: Texas birthing facilities covered by the newborn hearing screening (NBHS) mandated to electronically transmit records of all babies screened to DSHS. DSHS evaluates the data used for assessing performance and reports results monthly. Birthing facilities are required by Texas law to be certified by DSHS and meet specific performance standards. A facility is noted as being out of compliance if the NBHS program is below any of the standards for two (2) of the three (3) months in a quarter. Currently, there are 247 birthing facilities reporting data to DSHS. For FY '07, 98% of newborns were screened for hearing loss before hospital discharge with a 3% statewide average referral or re-screening rate. State performance goals are 95% of infants screened will pass and not refer for another screening. Facilities not meeting the minimum requirement of 90% passing rate are out of compliance and are notified monthly through email by the contractor and through certified mail by the department if the issues continue during month three after the notification. DSHS works with facility staff to identify solutions to the compliance

issues.

Activity 2: Conduct Texas Early Hearing Detection Intervention (EHDI) Coalition meetings every other month.

Update: The TEDI Coalition completed efforts to identify and resolve problems regarding referrals of children with hearing loss. With HRSA funds, Early Childhood Intervention (ECI) has access to DSHS web-based TEHDI system used in all birth facilities. ECI and Audiology providers now receive electronic referrals improving follow-up efforts. The Coalition disbanded after addressing the referral problems. DSHS continues to participate with ECI and Texas Education Agency on issues related to children with hearing loss and deafness.

Performance Assessment: The percent of newborns who receive a hearing screen has increased since 2000 when mandatory testing was first implemented. The percent exceeded 90% for the first time in 2006 with additional gains forecasted for 2007. Program activities continue to focus on ongoing technical assistance and continued implementation of a web-based system. These activities should help to maintain progress.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

On a weekly basis, Texas birthing facilities covered by the newborn hearing screening (NBHS) mandate electronically transmit to the DSHS contractor the records of all infants screened. The DSHS contractor tabulates the results on a monthly basis. Birthing facilities are required by law to be certified by DSHS and meet specific performance standards. A facility is out of compliance if the NBHS program is below any of the standards for two of the three months in a quarter. There are 247 birthing facilities reporting data to DSHS. For the first and second quarter, 98% of newborns were screened for hearing loss before hospital discharge with a 3% statewide average referral or re-screening rate. In the first quarter of FY08, 58 facilities were out of compliance and 45 facilities were out of compliance in the second quarter. Facilities that are out of compliance are notified monthly through email by the contractor and through certified mail by DSHS if the issues continue during month three after notification. The contractor works with facility staff to identify solutions to the compliance issues.

c. Plan for the Coming Year

Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.

Output Measure: Number of programs monitored by region, percent of compliant versus noncompliant programs, and the number of screens resulting in a positive diagnosis.

Monitoring: Document the results of monitoring through monthly reports generated the electronic monitoring system developed for this project.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	20	20	20	20	19.9
Annual Indicator	20.0	20.4	18.9	21.2	20.7
Numerator	1264446	1279078	1224279	1392038	1371955
Denominator	6330256	6263325	6476859	6555612	6628914
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	20	20	19	19	18

Notes - 2007

Data presents a projected linear trend for 2007 based on data from 2003 to 2006.

Notes - 2006

Data from http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Notes - 2005

Data from http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

a. Last Year's Accomplishments

Activity 1: Monitor and report the percentage of children without health insurance.

Update: According to estimates developed through the fiscal year, 20.7% of children ages 0-17 were uninsured.

Activity 2: Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.

Update: Title V-funded prenatal care, health and dental care services for children were provided through fee for service contractors who are required to screen and refer all clients for Medicaid and CHIP. In FY07, there were 40,579 individuals under the age of 21 served by these contractors.

Performance Assessment: With the exception of 2005, about one-fifth of Texas children are without health insurance. As data for 2006 and 2007 are still provisional, the potential impact of the implementation of the CHIP perinatal program has yet to be documented.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and report the percentage of children without health insurance.				X
2. Screen all children at Title V-funded clinics for potential CHIP (including the new CHIP perinatal benefit) and Medicaid eligibility and make referrals to appropriate programs.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Estimates are developed from various sources throughout the year.

Activity 2: Title V-funded prenatal care, health and dental care services for children continue to be provided through fee for service contractors who are required to screen and refer all clients for Medicaid and CHIP. In the first two quarters of FY08, there were 14,961 individuals under the age of 21 served by these contractors throughout the state.

c. Plan for the Coming Year

Activity 1: Monitor and report the percentage of children without health insurance.

Output Measure: Percent of children without health insurance.

Monitoring: Follow progress in developing periodic child health insurance status report.

Activity 2: Screen all children at Title V-funded clinics for potential CHIP (including the CHIP perinatal benefit) and Medicaid eligibility and make referrals to appropriate programs.

Output Measure(s): Percentage of children without health insurance who are enrolled into CHIP and other state-funded insurance programs as identified by Title V contractors.

Monitoring: Review claim data from contractors and quality assurance reports.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				23	22
Annual Indicator			23.7	23.9	21.3
Numerator			162380	160793	144873
Denominator			683968	671445	680536
Check this box if you cannot report the numerator					

because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	21	21	20	20	20

Notes - 2007

Source: WIC Database, Office of Title V and Family Health

Notes - 2006

Source: WIC Database, Office of Title V and Family Health

Notes - 2005

Source: WIC Database, Office of Title V and Family Health Planning

a. Last Year's Accomplishments

Activity 1: Expand development and use of FIT KiDS materials and curriculum in the participating WIC clinic sites.

Update: During FY07, a reprint of 500 sets of Fit Kids materials was initiated and 350 sets were then distributed to local WIC agencies. The final evaluation report was submitted to DSHS WIC at the end of the FY07. The evaluation concluded that The Fit Kids = Happy Kids flipchart is an effective educational tool. In the classroom, instructors were able to use the flipchart lessons to engage and inform clients, stimulate discussion, and encourage conversation and idea-sharing among clients. In individual sessions, counselors used flipchart lessons to address specific issues or challenges that a client may be facing with her child. Clients and staff remarked that the flipchart format was effective because of the highly visual, user-friendly way it presents the information. By breaking the information into 14 lessons and emphasizing key points with bullets that often include practical suggestions, clients found it easier to absorb the material.

Activity 2: Promote and support breastfeeding as the preferred infant feeding choice for WIC participants.

Update: During FY07, there were 350 WIC breastfeeding peer counselors providing services. WIC held two "train-the-trainer" peer counseling trainings with four participants and a Peer Counselor Workshop with twenty-four persons (made up of WIC directors, breastfeeding coordinators, lactation consultants, hospital nurses and others who were interested in establishing Peer Counselor Programs and training peer counselors). In FY07, 70.8% of women who received WIC services while pregnant attempted to breastfeed.

Activity 3: Identify the pregnancy correlates of obesity in early childhood (ages 2 to 4 years) among the WIC population.

Update: A paper entitled, "Overweight among Low-Income Texas Preschoolers Ages 2- to 4-Years" was completed. Data on children enrolled in WIC in April 2006 were matched with their mother's data for the analyses. Results indicate the following correlates of overweight in these children: mother's pre-pregnancy weight, high maternal weight gain during her pregnancy with the child, living in an urban or rural area, being Hispanic, being age 4 years old (compared to 2- to 3-year olds), and being male.

Performance Assessment: There was a decline in the proportion of children between the ages of two and five years with a BMI at or above the 85th percentile. By promoting breastfeeding and

implementing program such as FiT KiDS, the Texas WIC staff have contributed to this decline. Analyses of WIC client data will help to identify future leverage points for education and intervention to ensure continued declines in BMI.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote and support breastfeeding as the preferred infant feeding choice for WIC participants.			X	
2. Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: In the WIC population, breastfeeding initiation averaged 71.6% per month. Variation between months was less than half of a percentage point. Breastfeeding at 6 months was 45.0%. Twenty six participants completed the train-the-trainer peer counseling training offered by WIC. Of the 26 participants, 21 were WIC and 5 were non-WIC. 94.5% of WIC participants' are assigned a risk code indicating complications or potential complications with breastfeeding.

Activity 2: For the months of Oct '07 -- Dec '07, WIC served 1,073,582 unduplicated clients. Approximately 95.77% of WIC participants received nutrition education for a total of 1,028,169 WIC participants receiving nutrition education. Title V developed an RFP for treating childhood obesity in primary care settings to be distributed in Q3. Title V staff also participated in the Live Smart Texas Steering Committee for the RWJ grant for pediatric obesity. Title V staff is currently waiting on a response from their article submission to Pediatrics on "Overweight Among Texas Preschoolers 2-4 years."

NOTE: WIC Fiscal Year begins in October. Data for Q2 will not be available until late March- Early April.

c. Plan for the Coming Year

Activity 1: Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.

Output Measure: Number of WIC participants receiving nutrition education at time of benefit issuance. Type and number of activities included. Funding of WIC obesity projects. Funding registered dietitians at clinics to engage children at risk for obesity. Number of new mothers who choose to breastfeed.

Monitoring: Review quarterly WIC performance measure data on nutrition education contacts

Activity 2: Study food consumption patterns in WIC families.

Output Measure: Number of surveys and studies conducted to determine food consumption

patterns. Reports and presentations of findings.

Monitoring: Track quarterly progress on studies and analyses.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				7.3	7.2
Annual Indicator			7.4	7.9	7.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	7.5	7.4	7.3	7.2	7.1

Notes - 2007

Source: Data presents a linear trend based on PRAMS data from 2002 through 2006. Years prior to 2006 could not be updated due to TVIS limitations. The final percentages for previous years are as follows:

Year 2004 - 6.9

Year 2005 - 8.3

Notes - 2006

Source: The source for this data is PRAMS.

Notes - 2005

The source for this provisional data is PRAMS. Final and future reports will come from the Texas birth certificate which will include questions about smoking by trimester.

a. Last Year's Accomplishments

Activity 1: Promote smoking cessation to women ages 13-44, including pregnant women enrolled in WIC, through a Quitline/Great Start Faxed Referral Model.

Update: In FY 07, 3,966 were surveyed, 843 were smokers, 192 enrolled in the study, and 9 completed the study.

Activity 2: Review Pregnancy Risk Assessment Monitoring System (PRAMS) data for adults and teens by race and ethnicity to determine rates of smoking in the last three months of pregnancy and to identify co-factors.

Update: Data from the 2005 Pregnancy Risk Assessment Monitoring System (PRAMS) indicate that 15.0% of women surveyed reported that they smoked in the three months prior to becoming pregnant, 8.3% smoked in the last three months of pregnancy and 12.2% smoked following their delivery.

Activity 3: Using Geographic Information Systems (GIS) and related data sets, identify and compare areas of the state with the highest incidence of very low birth weight births and fetal exposure to tobacco, then develop and distribute a list of best practices.

Update: Staff turnover limited the GIS capacity in FY07. As resources for GIS increase, this activity will be completed.

Activity 4: Develop or procure and provide Texas Healthy Start Projects peer counselors/promotoras with information regarding smoking cessation during pregnancy.

Update: The six Texas Healthy Start projects focused on developing and promoting a bill for the Texas legislature related to the development of a Fetal-Infant Mortality Review process and adding information regarding the impact of smoking on birth outcomes to the signage required in venues where tobacco products are sold. The bill was successfully passed in the 80th Session of the Texas Legislature. The projects' staff met on a regular basis to discuss this process and Title V staff participated in these discussions as a resource. The Clinical Toolkit for Treating Tobacco Dependence is available for clinicians to download from the DSHS Tobacco Prevention and Control Program website.

Activity 5: Refine messages about timing of cessation in pregnancy.

Update: The birth data for 2005 that uses the 2003 Certificate of Live Birth and includes smoking behavior by trimester was not available in F07. Once available, analyses will be performed and shared with interested stakeholders.

Performance Assessment: The percent of women who smoke during their third trimester has remained relatively constant between 2005 and 2007. Increased focus on the preconception period may identify new opportunities for collaboration that could impact this measure.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote smoking cessation to women ages 13-44, including pregnant women enrolled in WIC, through a Quitline/Great Start Faxed Referral Model.	X			
2. Develop or procure and provide Texas Healthy Start Projects peer counselors/promotoras with information regarding smoking cessation during pregnancy.			X	
3. Review PRAMS data for adults and teens by race and ethnicity to determine rates of smoking in the last three months of pregnancy and to identify co-factors.				X
4. Using Geographic Information Systems (GIS) and related data sets to identify and compare areas with the highest incidence of very low birth weight births and fetal exposure to tobacco, and develop and distribute a list of best practices to address s				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The Quitline project has ended and was less successful than had been projected. Too few women completed the program to indicate a need to continue with that specific model.

Activity 2: The Women's and Perinatal Health Coordinator distributed smoking cessation materials (50 packets) at the Healthy Start conference held January 16-18, 2008. A meeting is planned with Title V staff and Behavioral Health Division staff for late March to discuss training on the Yes You Can Clinical Toolkit (smoking cessation) with Healthy Start sites.

Activity 3: Using PRAMS data, smoking in the last 3 months of pregnancy has remained between 6.9% and 8.3% in the population of pregnant women in Texas. In 2005, the rate was lowest among Hispanic women (4.4%) followed by African American women (8.3%) and White/Other women (13.3%). Exception among White/Other women, rates of smoking were higher in 2005 than in any previous year through 2002. These data will be added to the web site and communicated to key stakeholders in subsequent quarters.

Activity 4: Data have been geocoded for the 2004 birth year. Preparations for the analyses have begun.

c. Plan for the Coming Year

Activity 1: Develop SIDS prevention fact sheet that addresses secondhand smoke in conjunction with Texas Department of Family and Protective Services.

Output Measure; Development of English/Spanish fact sheet

Monitoring: Totals for fact sheet distributed. Document notification of key stakeholders of fact sheet availability

Activity 2: Coordinate with peer counselors/community health workers program to provide information regarding smoking cessation during pregnancy.

Output Measure: Number and type of materials provided to peer counselors/community health workers.

Monitoring: Track the distribution of materials on smoking cessation.

Activity 3: Monitor smoking rates of smoking in the last three months of pregnancy among adults and teens by race and ethnicity and to identify co-factors using birth record data and PRAMS.

Output Measure: Written review of data, including trends; data review communicated to external stakeholders including March of Dimes, Healthy Start, WIC and Title V fee-for-service and population-based providers; information placed on website, including referral resources for providers and clients.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	10	10	9	7.8	7.6
Annual Indicator	9.5	7.9	8.0	6.9	6.4
Numerator	162	136	141	125	115
Denominator	1701620	1726142	1756503	1810309	1792624
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	6	5	5	4	4

Notes - 2007

Data presents a projected linear trend for 2006 and 2007 based on vital statistics data from 2003 through 2005. Data from 2005 are preliminary.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

Notes - 2006

Data presents a projected linear trend for 2006 and 2007 based on vital statistics data from 2003 through 2005. Data from 2005 are preliminary.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

Notes - 2005

Data from 2005 vital statistics are preliminary.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

a. Last Year's Accomplishments

Activity 1: Provide support to the Texas Suicide Prevention Network in the implementation of the state suicide prevention plan

Update: Coalition activity included public awareness and outreach to media relations, the development of new survivor support groups, grant development for funding research in obtaining timely surveillance, advocacy support and public education.

Activity 2: For the Texas Youth Suicide Prevention (TYSP) Project, continue to implement the gatekeeper train-the-trainer program in Harris, Travis, and Bexar counties for identified gatekeeper agencies

Update: Gatekeeper training occurred at new target sites for key staff and community members in Bexar County (Center for Health Care Services, Brooke Army Medical Center (BAMC) Adolescent and Child Services clinic, and Cole Middle and High School health clinics) as well as Travis and Harris Counties. The project trained 868 Gatekeepers and 17 Instructors. The first TYSP annual symposium occurred in June 2007 and was attended by key community leaders from around the state. National experts presented topics ranging from media coverage of suicide, various school suicide prevention programs, and current resources available for communities to implement suicide prevention programs and to support survivors.

Activity 3: Implement the primary care screening and intervention component of the TYSP Project.

DSHS secured a contract with the Center for Health Care Services to assist in the delivery of the service component which includes implementation of a screening tool in several primary care

settings. Youth presenting at several primary care clinics who are dependents of wounded veterans receiving care at the BAMC will receive the screening tool and appropriate intervention. The service component was sent to the IRB and approval is pending.

Activity 4: Collaborate with the Policy Academy to develop a state action plan to improve services for co-occurring substance abuse and mental disorders.

Update: As a result of collaboration between Title V, Substance Abuse Division, and Texas Cancer Council, the Education Service Center (ESC) Project was formed. Through the ESC, School Health Specialists provide training on various health topics to the school districts. Materials for the Train-the-Trainer workshop for the ESC Health Specialists were developed for use in training school staff.

Activity 5: Report on suicide deaths of 15 -19-year-olds and develop policy recommendations aimed at prevention.

Update: The 2006 Texas State Child Fatality Review Team Annual report was published in December 2006. The report included data and analysis pertaining to suicides reviewed by local child fatality review teams (CFRTs) and data provided by the Texas Center for Health Statistics. The report is available at <http://www.dshs.state.tx.us/mch/pdf/TEXASC~1.pdf>.

Activity 6: Support the Texas Adolescent Mental Health in Primary Care Initiative (TAMHPCI) in the implementation of a feasibility study of behavioral health screening, assessment, treatment and/or referral of adolescents in the primary care setting.

Update: The initial feasibility study has been completed. A report on findings from the initial project phases is pending. Findings from the initial phases of the project will be used for strategic planning in FY08.

Activity 7: Collaborate and provide support to DSHS workgroups created by the Mental Health Transformation Workgroup that relate to suicide prevention for adolescents.

Following staff changes in DSHS, the workgroup meetings were limited and eventually suspended. Prior to the suspension of workgroup meetings, two ideas were generated and implemented by the Title V staff. First, a section on suicide was developed to include in the 2007 State Child Fatality Review Team Annual Report. Second, an analysis of inpatient suicide hospitalization was undertaken to understand better trends in the data.

Performance Assessment: Suicide rates among youth ages 15 to 19 years continue to decline in Texas and make progress toward the annual performance objective of 4.0 deaths per 1,000 youth ages 15 to 19 years. To reach this goal, Texas continues to explore the feasibility of innovative methods for expanding access to mental health services, such as integrating adolescent mental health screening and treatment into primary care settings, and to support collaborative efforts to ensure a multidimensional understanding of and approach to preventing youth suicide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide support to the Texas Suicide Prevention Community Network and Community Mental Health Project grants in the implementation of the state suicide prevention plan.				X
2. For the Youth Suicide Prevention Project, continue to implement the gateway train-the trainer program in Harris, Travis, and Bexar counties for identified gatekeepers (e.g., Texas Youth Commission, Texas Department of Family and				X

Protective Services)				
3. Implement the primary care screening and intervention component of the Youth Suicide Prevention Project.			X	
4. Report on suicide deaths of 15 to 17-year-olds and develop policy recommendations aimed at prevention.				X
5. Convene the TAMHPCI partners to plan and implement the initial phase of the large scale comparative study.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Activities included procurement of a grant for surveillance of suicide deaths in Austin (highest in Texas) and extensive activities in response to a cluster. Four presentations to community stakeholders by a national expert were conducted, as was a press conference that increased community awareness of warning signs and services. Screening was conducted at 2 middle schools, with 103 students screened and 27 with positive screens. Two presentations were given to 450 students. Gatekeeper training was presented to 56 teachers.

Activity 2: Gatekeeper training occurred at five sites in Bexar County and sites in Travis and Harris Counties. Through Education Service Centers, 7 workshops were offered in 7 regions and attended by 162 school staff. In the first two quarters of FY08, specialists trained 328 gatekeepers.

Activity 3: Screening/intervention began for youth, dependents of veterans receiving care at BAMC. Of the 143 screened; 54 had positive screening results (48 were referred for outpatient services and 6 for inpatient services.) TYSP sent 700 packets home with students in targeted schools. The project is complimented by new grant focused on serving the needs of Hispanic youth. Work has been done on translating materials, training bilingual instructors and gatekeepers, and distributing 975 Spanish language brochures.

Activity 4: DSHS Suicide Prevention Strategic plan is currently being revised.

Activity 5: Feasibility report completed and under current review.

c. Plan for the Coming Year

Activity 1: Provide support to the internal and external stakeholder workgroups addressing suicide prevention.

Output Measure(s): Number of communities impacted; Number and type of suicide prevention activities implemented; Number and types of grants applied for; Number and types of grants secured; Number of trainings completed; Number of attendees at trainings. Groups include, but are not limited to, Texas Suicide Prevention Community Network, TYSP Project, ESCs, Suicide Prevention Committee, and Texas Suicide Prevention Council.

Monitoring: Track the progress of the Network; track the activities within participating communities.

Activity 2: Provide support to the Community Mental Health Suicide Prevention (CMHP) projects Friends for Life CMHP and El Centro de Corazon.

Output Measures for Friends for Life CMHP: Number and types of prevention trainings held and

description of target audience; estimated number of participants; number of brochures distributed; number of locations; PSAs distributed number of newsletters developed and distributed; other outreach activities.

Monitoring: Track numbers through quarterly reports submitted to DSHS.

Output Measures for El Centro de Corazon: Number of teens screened; number of positive screens in the school setting; number of teens referred for further assessment; number of schools and grade levels screened; other types of screening sites.

Monitoring: Track numbers through quarterly reports submitted to DSHS.

Activity 3: Report on suicide deaths of 15 to 17-year-olds and develop policy recommendations aimed at prevention.

Output Measure(s): Public awareness/educational materials developed; suicide deaths of 15 to 17-year-olds reported in the State CFRT Committee annual report; number of trainings on developing suicide prevention initiatives presented to CFRTs; number of local initiatives developed by CFRTs; development of State CFRT subcommittee on prevention to collect local CFRT recommendations and prevention initiatives through quarterly CFRT prevention reports.

Monitoring: Track materials that are developed; provide updates of 15 to 17-year-old suicide deaths and recommendations at quarterly State Committee meetings.

Activity 4: Convene the TAMHPCI partners to plan and implement the next steps in the further study of integrating mental health into primary care settings.

Output Measures: Contract developed between DSHS Title V and Texas Tech University; number of meetings

Monitoring: Track the progress of contract development; meeting minutes.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	55	55	55	55	55
Annual Indicator	52.4	48.8	48.5	50.0	49.7
Numerator	2690	2674	2742	2839	2904
Denominator	5133	5482	5651	5683	5839
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	52	52	54	54	55

Notes - 2007

Data presents a projected linear trend for 2006 and 2007 based on vital statistics data from 1996 through 2005. Data from 2005 are preliminary.

The number of vlbw infants delivered at facilities for high-risk deliveries was determined by calculating the number of vlbw births at level 3 hospitals based on the 2005 American Hospital Association Survey.

Notes - 2006

Data presents a projected linear trend for 2006 and 2007 based on vital statistics data from 1996 through 2005. Data from 2005 are preliminary.

The number of vlbw infants delivered at facilities for high-risk deliveries was determined by calculating the number of vlbw births at level 3 hospitals based on the 2005 American Hospital Association Survey.

Notes - 2005

Data from 2005 vital statistics are preliminary.

The number of vlbw infants delivered at facilities for high-risk deliveries was determined by calculating the number of vlbw births at level 3 hospitals based on the 2005 American Hospital Association Survey.

a. Last Year's Accomplishments

Activity 1: Analyze birth data to identify areas in Texas where very low birth weight infants are not being delivered at Level III facilities.

Update: Staff turnover in FY07 delayed the implementation of this activity. By the end of FY07, research staff along with the Texas Women's Health and Perinatal Coordinator were collaborating on the definitions and design needed to complete this study in the future.

Activity 2: Develop a process to facilitate appropriate referrals for at-risk clients to facilities for high-risk deliveries and neonates and assess perinatal care facilities as basic, specialty, or subspecialty by using Geographic Information System tools.

Update: Without the available analyses, this activity was not completed in FY07. Plans were made to continue efforts to promote systems that encourage the referral to and use of high-risk facilities for appropriate deliveries.

Performance Assessment: About half of all deliveries of very low birth weight infants occurred at facilities for high-risk deliveries and neonates. Increased interest from the Fetus and Newborn Subcommittee of the Texas Medical Association has created a new partner for Title V in disseminating information that could impact this measure. Future activities will focus on determining correlates of delivering at an appropriate facility and educating providers about their referral options.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a process to facilitate appropriate referrals for at-risk clients to facilities for high-risk deliveries and neonates and ensure the continued assessment of perinatal care facilities as basic, specialty or subspecialty by using Geographic Inf				X
2. Provide an analysis of barriers to delivery in high risk facilities for high risk mothers using birth record data, data from the Hospital Survey Unit, and GIS technology.				X

3. Develop a letter to practicing obstetricians and other stakeholders that includes high risk perinatal care facilities as well as regional maps of their locations.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Research staff have collaborated with GIS staff in the Texas Center for Health Statistics to geocode all hospitals and include a variable to distinguish high risk facilities from all others. The design for the research study has been identified and will be implemented in subsequent quarters.

Activity 2: Research paper is in progress to identify correlates of being seen in high risk facilities. The design of the project has been developed and will be implemented in subsequent quarters.

Activity 3: No activity to date due to delay in Activities 1 and 2. Activity will commence in subsequent quarters.

c. Plan for the Coming Year

Activity 1: Provide an analysis of barriers to delivery in high risk facilities for high risk mothers using birth record data, data from the Hospital Survey Unit, and Geographic Information Systems (GIS) technology.

Output Measure: Report detailing sociodemographic and geographic barriers.

Monitoring: Quarterly progress reports.

Activity 2: Develop a process to facilitate appropriate referrals for at-risk clients to facilities for high-risk deliveries and neonates and ensure the continued assessment of perinatal care facilities as basic, specialty or subspecialty by using GIS maps, receiving input from local providers, developing and disseminating educational materials for providers, soliciting input from stakeholders, and tracking referral patterns in selected areas.

Output Measure: Number of referrals (origins/destinations) made for at-risk clients to facilities for high-risk deliveries; number of GIS maps developed; number and type of materials developed; number of materials distributed; number of stakeholder meetings convened and/or amount and type of input received from local providers; number of stakeholder organizations represented at meetings.

Monitoring: Document minutes from stakeholder meetings or documentation of other means of receiving input from local providers and track referral patterns.

Activity 3: Develop a letter to hospitals and other stakeholders that includes high risk perinatal care facilities as well as regional maps of their locations.

Output Measures: Letters to providers; lists of perinatal care facilities; maps of the locations of perinatal care facilities.

Monitoring: Number of letters sent annually.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	85	85	85	85	85
Annual Indicator	79.7	81.6	71.3	71.8	72.2
Numerator	300927	311089	274856	280353	285960
Denominator	377374	381441	385580	390713	396180
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	73	74	74	75	75

Notes - 2007

The percent receiving care in the first trimester is substantially different from years prior to 2005 because of a change in birth certificate format in 2005 and how this data was calculated. Trend data for 2006 and 2007 were calculated by increasing the numerator by 2% a year based on the average increase in previous years.

The denominators for 2006 and 2007 were based on a linear trend from 1996 to 2005. Data from 2005 are preliminary.

Notes - 2006

The percent receiving care in the first trimester is substantially different from years prior to 2005 because of a change in birth certificate format in 2005 and how this data was calculated. Trend data for 2006 and 2007 were calculated by increasing the numerator by 2% a year based on the average increase in previous years.

The denominators for 2006 and 2007 were based on a linear trend from 1996 to 2005. Data from 2005 are preliminary.

Notes - 2005

The percent receiving care in the first trimester is substantially different from years prior to 2005 because of a change in birth certificate format in 2005 and how this data was calculated.

Data from 2005 vital statistics are preliminary.

a. Last Year's Accomplishments

Activity 1: Allocate Title V funds through a population-based competitive or continuation Request For Proposals (RFP) in targeted areas/subpopulations of the state to obtain the best birth outcomes.

In FY2007, a continuation RFP was released to support awards made in FY2006 in targeted areas/subpopulations of the state to address teen pregnancy, STDS, adequacy of prenatal care

and low birth weight. Sixteen continuation awards were made with 8 contractors entering their second year of funding and 8 entering their third. Ten of these contracts specifically addressed adequacy of prenatal care. (A roster of all contractors and their topic areas is included in Attachment IV.C. NPM8.)

Activity 2: Review curricula for promotora/community health worker-based home visiting programs to identify and/or develop a curriculum for implementation in identified geographic locations in Texas, and promote to external stakeholders.

Update: Several models/curricula have been reviewed, including the Nurse-Family Partnership, Partners for a Healthy Baby (Florida State University), Healthy Families Travis County and the Mother-Love Model. Also, there are several home visiting models being tested through the Title V Population-based grant program. Staff have reviewed these models and are monitoring their implementation and effectiveness. Title V staff have worked with the DSHS Community Health Worker (CHW) Program to assist the program in developing its strategic plan for the future and to identify ways in which Title V can work with the CHW Program. More than 600 promotoras/community health workers have been certified through the DSHS CHW Program, and there are 11 certified training sites. In the spring of FY07, the CHW Program was moved into the Office of Title V and Family Health. The move will provide greater opportunities to explore ways for CHWs and promotoras to promote the importance of prenatal care during the first trimester.

Performance Assessment: The percent of women receiving adequate prenatal care is approximately 10 percentage points lower between 2005 through 2007 as compared to 2003 through 2004. Analysis of birth record data has identified significant geographic disparities of twenty percentage points or more between counties. This information will be useful when planning future activities. Regional staff will also continue to have a significant role in ensuring that women who are eligible for public assistance receive these benefits. Messages focusing on preconception health and preventing unplanned pregnancies may also help to improve this outcome.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Allocate Title V funds through a population-based competitive or continuation RFPs in targeted areas/subpopulations of the state to obtain the best birth outcomes.			X	
2. Health Service Regions develop a population-based activity to ensure referral to the CHIP Perinatal Program and Medicaid.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: There are currently sixteen contracts to local providers, some of which address prenatal care. Eight of these contracts terminate at the end of FY08. Of these contracts ten address adequacy of prenatal care. Four of these contracts terminate at the end of FY08. In addition, there were 41 Title V-funded contractors providing prenatal care throughout the state.

Activity 2: Texas became the 9th state to extend CHIP benefits to women who are not eligible for Medicaid and qualify based on income thresholds. Plans were developed with Title V staff to ensure that women were appropriately referred, enrolled, and receive this benefit. The Health Service Regions have agreed on the plans and they will be implemented in January 2008.

c. Plan for the Coming Year

Activity 1: Increase awareness of the need for early prenatal care among women in the preconception period.

Output Measure(s): Number of women engaging in early prenatal care.

Monitoring: Review quarterly progress reports.

Activity 2: Health Service Regions develop a population-based activity to ensure referral to the CHIP Perinatal Program and Medicaid.

Output Measure(s): Number of Service Level Agreements that identify activity and number of pregnant women referred for each program.

Monitoring: Review quarterly reports.

D. State Performance Measures

State Performance Measure 1: *Change in percentage of CSHCN living in congregate care settings as percent of base year 2003*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				95	90
Annual Indicator			99.3	100.1	99.4
Numerator			1606	1619	1608
Denominator			1617	1617	1617
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	90	85	85	80	80

Notes - 2007

Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2007.

Notes - 2006

Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2006.

Notes - 2005

Health and Human Services Commission Report

a. Last Year's Accomplishments

Activity 1: Provide, or support the provision of, permanency planning and case management services to families of CSHCN at risk of, or in, out-of-home placement.

Update: During FY07, DSHS regional staff and CSHCN SP contractors assisted 1,800 CSHCN and their families with permanency planning. DSHS regional staff and CSHCN SP contractors send a uniform letter to CSHCN who are turning 16 years old to initiate a conversation about permanency planning. DSHS regional staff and CSHCN SP contractors participated in statewide permanency planning training sponsored by the Department of Aging and Disabilities (DADS).

The Health and Human Services Commission's (HHSC) report for SB 368 noted that 1,608 children resided in institutions for the period ending 8/31/07. During the reporting period ending 8/31/07, 159 children moved to less restrictive environments (other than family-based settings). An additional 132 children moved to family-based settings. While the total number of children in institutions has remained around 1,600 for the past several years, residential settings continue a shift to smaller, less restrictive environments.

DADS received funding from the 79th Texas Legislature to serve additional persons, including children, from the Medicaid waiver interest lists. For FY06 and FY07, over 1,500 children from the Medically Dependent Children's Program (MDCP) interest list were enrolled in MDCP. An additional 1,100 children were in the enrollment process. The number of children released and enrolled from other Medicaid waiver program interest lists was not available.

The 80th Texas Legislature provided additional funding to reduce interest lists at DADS, DSHS, and DARS during the 2008-2009 biennium. Funding was designated to provide 250 Home and Community-based Services slots to assist state school residents to move to the community. Through the Texas Promoting Independence Initiative, funds were designated to assist 180 clients move from large ICF/MRs to community-based programs. Other funds were identified to assist 120 children aging out of foster care to move to community-based programs. HHSC continued to contract with EveryChild, Inc., to develop and implement a system of family-based alternatives in several areas in Texas.

Activity 2: Fund respite and other family support services through contracts and CSHCN SP Healthcare Benefits.

Update: During FY07, contractors provided family support and community resources for nearly 900 CSHCN and their families. CSHCN SP health care benefits provided Family Support Services (FSS) to over 50 eligible clients, including respite, van modifications, home modifications, and other family support services. CSHCN SP expended \$128,160 for FSS during FY07. CSHCN SP staff developed training materials and tools to assist regional staff in developing FSS authorization. An article on FSS for CSHCN was published in the CSHCN SP Newsletter for Families.

Activity 3: Participate in state-level committees/task forces to collaborate with consumers, providers, and other state and private agencies to support permanency planning and family-based community living options for CSHCN who are at risk of placement or who currently reside in institutions or congregate care settings.

Update: Title V staff continued to participate in such forums as the Children's Policy Council (CPC), Promoting Independence Advisory Committee (PI), Money Follows the Person (MFP) statewide and regional workgroups, Texas Integrated Funding Initiative (TIFI), and Texas Council in Developmental Disabilities (TCDD). CSHCN SP contractors and Regional staff participate in community forums, such as conferences, committee meetings, and local Community Resource Coordination Groups (CRCG). The MFP Initiative received additional federal funding to expand efforts to assist persons to move from a facility and to receive community-based services. DADS and HHSC convened an external advisory committee to assist the state in implementing the grant. DSHS regional staff will conduct client assessments for the new Personal Care Services Medicaid benefit for eligible children.

Performance Assessment: As of 8/31/07, 1,608 children resided in an institution. While the total

number of children in institutions as defined by SB 368 has remained fairly steady, residential settings continue a shift to smaller, less restrictive environments.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide, or support the provision of, permanency planning and case management services to families of CSHCN at risk of, or in, out-of-home placement.		X		
2. Fund respite and other family support services through contracts and CSHCN SP Healthcare Benefits.		X		
3. Collaborate with contractors, state agencies, and other entities to support permanency planning and family-based living options for CSHCN who reside in or are at risk of placement in congregate care settings.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: During the first half of FY08, CSHCN SP regional staff and contractors assisted over 430 CSHCN and their families with permanency planning.

Activity 2: During the first half of FY08, ten contractors provided family support services for over 900 CSHCN and their families. CSHCN SP health care benefits provided family support services to eligible clients, including respite, van and home modifications, and other family support services. CSHCN SP expended \$26,000 for family support services during this period. The Program provided training to regional and contractor case managers on family support services and other CSHCN SP healthcare benefits.

Activity 3: The CSHCN SP collaborated with Every Child Inc to provide training and resources for DSHS regional staff and CSHCN SP contractors to improve permanency planning. CSHCN SP included information regarding permanency planning activities in the Promoting Independence Advisory Committee (PIAC) quarterly report to the Legislature. Title V staff continue to participate in community forums, such as Children’s Policy Council, PIAC, Money Follows the Person statewide and regional workgroups, Texas Integrated Funding Initiative, and Texas Council for Developmental Disabilities. CSHCN SP contractors and Regional staff participated in community forums, such as conferences, committee meetings, and local Community Resources Coordination Groups.

c. Plan for the Coming Year

Activity 1: Provide, or support the provision of, permanency planning and case management services to families of CSHCN who are at risk of, or in an out-of-home placement.

Output Measure(s): Number of CSHCN assisted with permanency planning by CSHCN SP regional and contractor case management staff; information on placements of CSHCN with alternative families, and admissions and discharges for CSHCN from congregate care settings (nursing homes, state schools, ICFs-MR), as data is available.

Monitoring: Review quarterly regional activity reports, contractor quarterly reports, and data from the Health and Human Services Commission.

Activity 2: Fund respite and other family support services through contracts and CSHCN SP Healthcare Benefits.

Output Measure(s): Number of respite and other family support services programs funded through CSHCN SP contracts; number of CSHCN provided respite and other family support services through CSHCN SP contractors and health care benefits.

Monitoring: Review quarterly reports from the CSHCN SP health care benefits database, CSHCN Management Information System, and contractor quarterly reports.

Activity 3: Collaborate with contractors, state agencies, and other entities to support permanency planning and family-based living options for CSHCN who reside in or are at risk of placement in congregate care settings.

Output Measure(s): Documentation of participation in, and recommendations or actions of, related committee, agency or organization meetings; related contractor activities.

Monitoring: Review Stakeholder Meeting reports on relevant meetings attended by CSHCN SP staff, contractor quarterly reports, and reports of other activities.

State Performance Measure 2: *The percent of obesity among women ages 18 to 44*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				23	22.5
Annual Indicator			23.6	24.5	25.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	22	21.5	21	20.5	20.5

Notes - 2007

BRFSS is a sample survey, therefore, the numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting. Data are provisional because the weights were calculated by DSHS and the final weights have not been received from the CDC yet.

Notes - 2006

BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

Notes - 2005

BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

a. Last Year's Accomplishments

Activity 1: Review the effectiveness of the "WIC Wellness Works" program on improving fruit and vegetable consumption, physical activity, role behavior and work climate in targeted WIC clinic sites among WIC employees

Update: Currently, 1,500 WIC staff across Texas are participating in WIC Wellness Works (WWW). WWW is in approximately 42 local agencies.

Activity 2: DSHS regional staff conduct skill building workshops and provide technical assistance in order to facilitate the development of community collaborations around the topics of nutrition and physical activity.

Update: In FY07, skill building workshops designed to facilitate the development of community collaborations around the topics of nutrition and physical activity with an emphasis on policy and environmental change, were held throughout Health Service Regions 6, 7, 8, and 9. Initial evaluations for all workshops showed a positive response from attendees regarding the information and data presented as well as speaker's knowledge and expertise. No additional evaluation data are available.

By the end of FY07, Regional Nutritionist staff in Public Health Service Region 8 conducted one additional skill building workshop for FY07. Thirty attendees from nine counties in both Health Service Regions 8 (centered around San Antonio) and 5/6 (centered around Houston) were trained on visioning and gathering stakeholder interests in their community around physical activity and nutrition for the purpose of obesity prevention.

Regional staff continued to provide technical assistance to guide groups and partnerships formed from original skill building workshops conducted in FY06 and FY07 to determine what specific interventions these groups would like to focus on for the coming fiscal year. Besides Skill Building workshops, 10 additional workshops and trainings that also focused on policy and environmental change to reach communities at the population versus the individual level were conducted in Region 1 Lubbock area; Region 2/3 Dallas area; Region 5/6 Houston area; and Region 9/10 El Paso area. Although all focused on general nutritional strategies to combat obesity, the following strategies were also included:

- Physical Activity (6 out of the 10 trainings)
- Fruit and Vegetables (6 out of the 10 trainings)
- Weight Management and Weight Loss (5 out of 10)
- Breastfeeding (4 out of the 10)
- Decreased Portion Size (4 out of the 10)
- Reducing sugar-sweetened beverage consumption (4 out of the 10)
- Reducing television/screen time (3 out of the 10)

In summary, the statewide demographics of the audiences trained were as follows: 254 adults (235 female; 19 male); 67% Caucasian; 20 % Hispanic; 11% African-American; and 2% Other.

An external contract through the DSHS Central Office Nutrition, Physical Activity and Obesity Prevention Program (NPAOP) and the City of Fort Worth in Health Service Region 2/3 funded four (4) Promotora trainings using a community-based physical activity promotion curriculum. The trainings were held in Austin, Weslaco, El Paso and Dallas. DSHS Central Office NPAOP has provided a work plan 'menu' with objectives to Regional Nutrition staff who in turn present these options to community groups. The 'menu' includes the following intervention projects: NEMS (Nutrition Environment Measures Survey); TexPlate -- restaurant-based portion control program; Farm to Work -- sustainable fruit and vegetable program for worksites; and Regional built environments survey -- a collaborative assessment project through the Texas Active Living Network.

Performance Assessment: The percent of obesity among women ages 18 to 44 years increased for the second consecutive year. It is likely that since this measure is populated using BRFSS data that indicator is underreported. Future activities need to include policy and environmental changes that support healthy eating and physical activity. WIC programs such as WIC Wellness

Works, the introduction of the new WIC food package, and a continued commitment to increase breastfeeding rates also will contribute to improvement in this measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review the effectiveness of the "WIC Wellness Works" (WWW) program on improving fruit and vegetable consumption, physical activity, role behavior and work climate in targeted WIC clinic sites among WIC employees.				X
2. DSHS regional staff, under the direction of the Nutrition, Physical Activity and Obesity program, conduct skill building workshops and provide technical assistance in order to develop community collaborations around nutrition and physical activity.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: "WIC Wellness Works" (WWW) staff participation level is between 1700-1800. During January 08, 23 WIC participated in New Coordinator Training. Three Texas WIC News WWW inserts have been completed and submitted for publication. Three WWW educational packets have been created. The University of Texas staff is currently soliciting feedback from local agencies on their interest and need for client education wellness materials linked to the worksite program. Additionally, the University of Texas staff is working with state WIC staff on creating a DVD containing 10 wellness segments based on past Interactive Distance Learning wellness breaks.

Activity 2: Although there have been no skill building workshops though the first quarter of FY08, three other types of workshops were conducted: two in Health Service Region 7 based out of Temple and one in Health Service Region 2/3 based out of Arlington. Topics included general nutrition, physical activity, weight management, and weight loss and were presented to a total of 132 adult females (77 Caucasian; 40 Hispanic; and 33 African American).

c. Plan for the Coming Year

Activity 1: DSHS Central Office and Regional Office staff of the Nutrition, Physical Activity and Obesity Prevention (NPAOP) Program will conduct trainings and provide technical assistance aimed at supporting community level (city/county) policy and environmental changes that address one or more of the four evidence-based obesity prevention strategies as defined by the Centers for Disease Control.

Output Measure: Number of trainings and participants; number and type of organizations trained or assisted; number and type of topics addressed; summary reports on activities of related policy and environmental changes.

Activity 2: DSHS Central Office and Regional Office staff of the Nutrition, Physical Activity and Obesity Prevention (NPAOP) Program will contribute to the implementation of policy and environmental changes in a minimum of 6 communities (including one border community) that

address one or more of the four evidence-based obesity prevention strategies related to nutrition as defined by the Centers for Disease Control.

Output Measure: Number and description of policies implemented; number of communities engaged; number and description of environmental changes implemented; summary reports on activities of related policy and environmental changes.

Monitoring: Program Management and Tracking System will provide Regional and community monthly reports according to output measures listed above.

Activity 3: Monitor obesity rates among women ages 18 to 44 years through the analysis of previously collected surveillance data (WIC annual Infant Feeding Practices Survey, Pregnancy Risk Assessment Monitoring System [PRAMS], Texas BRFSS).

Output Measure: Percent of mothers who initiate breastfeeding prior to hospital discharge; percent breastfeeding at six months; written review of data; data review communicated to external stakeholders including March of Dimes, Health Start, WIC, and Title V fee-for-service and population-based providers.

Monitoring: Review quarterly WIC data, and birth record, PRAMS, and National Immunization Survey data as available.

State Performance Measure 3: *Percent of licensed child care centers in metropolitan counties that have no deficiencies in operational policies that address health and safety of children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				90	90
Annual Indicator			0.0		30.1
Numerator			0		2806
Denominator			55	7500	9319
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	90.5	91	91.5	92	92

Notes - 2007

This is an estimate based on data provided through the annual report prepared by Texas Department of Family and Protective Services.

Further analysis based on targeted metropolitan statistical areas is ongoing.

Notes - 2006

The measure has been refined based on review of activities in FY07. Numerator is not available at this time.

Denominator is an estimate of total licensed child care centers in metropolitan areas.

Notes - 2005

Source:

<http://www.tea.state.tx.us/student.assessment/reporting/results/swresults/taks/2006/g3e.pdf>

Texas Education Agency, Student Assessment Division

a. Last Year's Accomplishments

Activity 1: Assess childcare infrastructure in the state at the regional and local level and identify priority areas of need for Child Care Health Consultation services.

Update: An assessment of the childcare infrastructure (the need for and utilization of child care health consultants) was initiated in FY2006 to assess the childcare infrastructure at that regional and local level and to identify Child Care Health Consultation priority needs.

Activity 2: Convene a summit of early childhood health and early care and education stakeholders to develop a best model for implementation of a Child Care Health Consultant (CCHC) program, define priorities in CCHC curriculum, and scope of practice.

Update: As part of the Texas Early Childhood Comprehensive Systems (TECCS) Implementation Plan, priority areas outlining how Healthy Child Care Texas (HCCT) would support each of the five component areas of the TECCS initiative were established. HCCT Task Force members and National Training Institute (NTI) trainers were then able to establish activities for each goal and objective, with responsible parties and timelines attached. The Scope of Practice was broadened for both NTI Trainers and CCHCs to include additional training/certification in such areas as Infant Mental Health, Positive Behavioral Support and a requirement that all NTI Trainers and CCHCs be registered in the Texas Early Care and Education Career Development System's Trainer Registry

Activity 3: Plan and develop a pilot project for Child Care Health Consultation based on identified best practices at a site identified as having high need for Child Care Health Consultant Services.

Update: A workgroup made up of staff from the Office of Title V and Family Health and Health and Human Services Commission (HHSC) was created to identify best practices and establish a strategy for an efficient and effective pilot program. The focus shifted to develop infrastructure that promotes best practices in health promotion and risk reduction in early care and education childcare settings through the use of HCCT, NTI trainers and CCHCs, and Community Health Workers (promotoras).

Performance Assessment: In FY07, of the 9,319 licensed child care centers, there were 8,912 non-abuse /non-neglect complaints filed with 2,806 resulting in noted deficiencies. By analyzing the data from the five Metropolitan Statistical Areas (MSAs) of the state with the highest relative number of deficiencies, the following deficiencies were identified as the most common:

- Administering Medication -Original Container with Child's Name, Date
- Annual Sanitation Inspection
- Diaper Changing Steps-Supplies Kept Out of Child's Reach
- First Aid Kit - Inaccessible to Children
- Safety - Air Conditioners, Fans, Heaters Safeguarded
- Safety - Areas Free From Hazards
- Safety - Electrical Outlets Covered
- Written Operational Policies -Hearing & Vision Screening

The collaborating agencies of HHSC, DFPS and Title V developed alternative plans to focus on activities to support licensed child care facilities in efforts to meet the minimum standards, targeting the MSAs in most need.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Assess childcare infrastructure in the state at the regional and local level and identify priority areas of need for Child Care Health Consultation services and other options for providing information to licensed child care centers.				X
2. Assess the options available and feasibility for developing an online child care health consultant course.				X
3. Assess the feasibility of developing a pilot project for Child Care Health Consultation based on identified best practices at a site identified as having high need for Child Care Health Consultant Services.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: A survey of child care health consultants was conducted in FY07 and reviewed in FY08 to assess the existing supply. To assess the demand, a survey of licensed day care facilities was completed in September 2007. Results indicated a need to refocus efforts to options other than child care health consultants to address child care licensing deficiencies identified by the Department of Family and Protective Services licensing staff.

Activity 2: Title V Staff have investigated possibilities of creating an online CCHC course, however the scope of Texas CCHC model is currently in transition and Title V has decided to focus efforts on a collaboration with DFPS and the utilization of health and safety deficiency data.

Activity 3: After assessment of data collected through the survey efforts of Title V staff, a decision was made to limit Title V support for the CCHC model. Title V will continue to work with the HCCT Taskforce and the Department of Family and Protective Services (DFPS) to explore possible alternatives to this model. Title V Staff, with the help of DFPS, determined the top Health and Safety deficiencies among child care facilities by MSA and by county. This data will be used to direct prevention activities.

c. Plan for the Coming Year

Activity 1: Explore opportunities with the DFPS Child Care Licensing to identify child care facilities with greatest infractions and provide targeted health and safety information.

Output Measure: Number of child care facilities targeted, number and type of materials produced.

Monitoring: Summary of activities, copies of materials.

State Performance Measure 4: *The proportion of women between the ages of 18 and 44 who are current cigarette smokers.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				17.5	17
Annual Indicator			18	15.9	19.3

Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	16.5	16	15.5	15	14.5

Notes - 2007

BRFSS is a sample survey, therefore, the numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting. Data are provisional because the weights were calculated by DSHS and the final weights have not been received from the CDC yet.

Notes - 2006

BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

Notes - 2005

BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

a. Last Year's Accomplishments

Activity 1: Work to expand the questions asked on the BRFSS to understand attitudes and knowledge of tobacco use among women of childbearing age.

Update: Additional questions that focus on tobacco use were not added in FY07. It is unlikely that these questions will be added. Funding was directed to add family planning questions and breastfeeding questions to the 2007 BRFSS.

Activity 2: Provide technical support, guidance and resources to local community groups that identify women of childbearing age as a special population disparately affected by smoking.

Update: The primary community-based organization that has identified women of childbearing age as a special population disparately affected by smoking in Texas is the March of Dimes (MOD). The MOD has requested data regarding smoking rates for women of childbearing age women on a regular basis via their request for general data and PRAMS updates.

Activity 3: Work with the Tobacco Prevention and Control Program to ensure that annual media campaign includes messages targeting women of childbearing age.

Update: Television, outdoor and Internet cessation advertisements ran in Amarillo in early March 2007. Television, outdoor, newspaper and Internet cessation advertisements ran in Tyler in early March 2007. Cessation ads ran on cable television in Beaumont in June through August 2007. Cessation theater ads ran in Beaumont and the Houston area in July and August 2007. Work began to redesign an existing toolkit for clinicians to counsel patients on cessation. The toolkit includes a brochure for pregnant women. Previously available only in English, the brochure has been translated to Spanish.

Activity 4: Develop materials that highlight the link between environmental tobacco smoke and Sudden Infant Death Syndrome (SIDS).

Update: Title V staff developed a brochure entitled Information for Parents of Newborn Children that discusses various aspects of parenting in the first few weeks and months postpartum. The brochure includes information on newborn screening, immunization, postpartum depression and shaken baby syndrome is included. Staff planned to add information on Sudden Infant Death Syndrome and safe sleep, including any links to environmental tobacco smoke exposure, with the updated immunization schedule for FY08.

Performance Assessment: In 2007, the rate of tobacco use among women 18 to 44 years of increased to the highest level in the three years during which this measure was reported. Activities should focus on continued and increased technical assistance to communities throughout Texas and continue to promote a multidimensional approach to reducing tobacco use through preconception health messages, SIDS prevention messages, and cancer prevention messages.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical support, guidance and resources to local community groups that identify women of childbearing age as a target population.				X
2. Work with the Tobacco Prevention and Control Program to ensure that annual media campaign includes messages targeting women of childbearing age.				X
3. Develop materials that highlight the link between environmental tobacco smoke and Sudden Infant Death Syndrome (SIDS).				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Trained six coalitions to implement comprehensive tobacco prevention and control programs including: City of Austin Health and Human Services Department, Ector County Health Department, Fort Bend County Health and Human Services Department, Lubbock-Cooper Independent School District, Northeast Texas Public Health District, and San Antonio Metropolitan Health District. Training included education on special populations that included pregnant women.

Activity 2: A paid placement of Spanish language tobacco prevention posters was provided to Beaumont-Port Arthur convenience stores Sept. 1-Nov. 2 2007. Posters were displayed in eight convenience stores (most near school campuses). Limited media activity took place during the 2nd quarter due to a transition of the program's operations from a single target area to six targeted areas. DSHS awarded tobacco prevention and control grants to the six communities noted above and additional media placements are currently being planned.

Activity 3: A SIDS fact sheet is in development by Title V staff. A revision of health education materials targeted to parents of newborns will include health information on safe-sleeping positions. The Office of Title V is participating in a collaborative health promotion campaign on Safe Sleep in conjunction with the Texas Department of Family and Protective Services which includes the development of health promotion messages targeted to pregnant and parenting women and their families.

c. Plan for the Coming Year

Activity 1: Provide smoking cessation training using the Yes You Can Clinical Toolkit to include WIC, DSHS regional staff, prenatal contract staff, Department of Family and Protective Services

staff and other key stakeholders through regional tobacco prevention and control staff.

Output Measure: Number of trainings held.

Monitoring: Monthly total of training sessions held.

Activity 2: Distribute cessation and secondhand smoke educational materials (targeted to pregnant women) through Prevention Resource Centers.

Output Measure: Documentation of distribution to all region-based Prevention Resource Centers to include delivery methodology and materials.

Monitoring: Number of hits on Prevention Resource Center websites

State Performance Measure 5: *The prevalence of at-risk for obesity and obesity among adolescents enrolled in high school*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				28	27
Annual Indicator			29	29	31.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	26	25	24	23	22

Notes - 2007

Source: Texas, 2007 Youth Risk Behavior Survey (YRBS).

Notes - 2006

Source: Texas, 2005 Youth Risk Behavior Survey (YRBS) Results.
<http://www.cdc.gov/HealthyYouth/yrbs/pdf/mortality/texas.pdf>

Notes - 2005

Estimate is based on 2005 YRBS. Since YRBS is a sample survey, numerator and denominator data are not applicable.

Source: Texas, 2005 Youth Risk Behavior Survey (YRBS) Results.
<http://www.cdc.gov/HealthyYouth/yrbs/pdf/mortality/texas.pdf>

a. Last Year's Accomplishments

Activity 1: Promote and support breastfeeding as the preferred infant feeding choice for Texans among community leaders and women throughout the population.

Update: The Breastfeeding Report Card, United States 2007 indicates that 75.4% of infants in Texas were ever breastfed, 37.3% breastfed at 6 months, 18.7% breastfed at 12 months, 25.2% exclusively breastfeeding at 3 months, and 7.1% exclusively breastfeeding through 6 months. There were three Peer Counselor Training Workshops in the first quarter of FY2007 with a total of 31 participants. There were 69 Mini I Breastfeeding Workshops with a total of 1,514 participants. There were 34 Mini II Breastfeeding Workshops with a total of 602 participants. There were five Principles of Lactation Management (POLM) classes with a total of 279 participants. There were six Lactation Counseling and Problem Solving (LCAPS) class with a total of 135 participants. WIC

breastfeeding rates were approximately 71.2%. The following WIC breastfeeding materials have been produced: 4 motivational brochures for pregnant moms, including a teen brochure; 7 motivational brochures for partners, grandparents, community members targeted at the African American community; 14 instructional brochures for pregnant moms; 1 Mother-Friendly Worksite brochure; The Physician Pocket Guide to Breastfeeding; Community Action Kit for Protecting, Promoting, and Supporting Breastfeeding; 14 breastfeeding posters; and Breastfeeding Welcome Here business decals and flyers. There were 5 Mother Friendly Worksites approved in FY07. There were 5 hospitals and birthing centers approved for accreditation through Texas Ten Steps in FY07.

Activity 2: Implement and evaluate a pilot project for the Nutrition and Physical Activity Self-Assessment for Child Care (NAPSACC) intervention for preschool children in Corpus Christi.

Update: Title V staff are continuing efforts to carry out the activity, however it was not completed in FY07 and has been included in planned activities for FY08.

Activity 3: Collaborate with the School Physical Activity Nutrition (SPAN) group to continue collecting data on demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th, 8th and 11th grade children.

Update: School Physical Activity and Nutrition (SPAN) data are available for the 2000 through 2002 and 2004/2005 school years. Title V staff meet regularly with university partners to plan analyses of these data. In FY07, analyses on school lunch decision-making, urban and rural differences, and the association between depression and food intake were initiated.

Activity 4: Collaborate with Texas Tech University and the Lubbock Independent School District to analyze 25 years of school BMI data as it related to policy changes.

Update: Texas Tech University and Title V have entered into a contract to complete this work. Due to changes in administration at Texas Tech University, the FY07 deliverables were not completed. To continue this work, Title V staff will pursue similar opportunities with other academic institutions.

Activity 5: Explore collaborations with Baylor University School of Medicine, Division of Adolescent Health to develop and test innovative solutions to reduce adolescent obesity.

Update: In 2007, the relationship with Baylor University School of Medicine, Division of Adolescent Health and Title V was developed. This relationship led to the DSHS Adolescent Health and Child Health Coordinators attending five LEAH conferences at Baylor. While general in nature, these trainings have led to the development of better and more complete ideas about preventing childhood obesity.

Performance Assessment: Nearly one-third of Texas high school students report themselves to be obese. Surveillance is needed to provide an understanding of the precursors of obesity in the adolescent population in order to develop innovative solutions. Activities will focus on innovative projects and addressing policy and environmental factors.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement and evaluate a pilot project for the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) intervention for preschool children in Corpus Christi.				X
2. Collaborate with the School Physical Activity Nutrition (SPAN) group to continue collecting data on demographics, nutrition				X

behaviors, attitude and knowledge, and physical activity behaviors among 4th, 8th and 11th grade children.				
3. Collaborate with Texas Tech University and the Lubbock Independent School District to analyze 25 years of school BMI data as it related to policy changes.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The pursuit of funding for the Nutrition and Physical Activity Self-Assessment for Child Care (NAPSACC) program was unsuccessful as of end of FY06 and the program has since been dropped from all NPAOP work plan and objectives. To continue efforts around policy and environmental change in specific sectors, NPAOP has finalized work plan 'menu' consisting of the following intervention projects: NEMS (Nutrition Environment Measures Survey) for grocery stores, convenient stores and restaurants; TexPlate -- a restaurant-based portion control program; and Farm to Work -- a sustainable fruit and vegetable program for worksites.

Activity 2: Two manuscripts have been submitted on obesity with DSHS authors. One poster presented at MCH Epi used these data. Meetings occur every other Wednesday to discuss papers and progress.

Activity 3: Internal problems and staff departures at Texas Tech University have caused this contract to end. No activities were or will be initiated.

c. Plan for the Coming Year

Activity 1: Collaborate with the School Physical Activity Nutrition (SPAN) group to continue collecting data on demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th, 8th and 11th grade children.

Output Measure: Prevalence of overweight among Texas school children by grade, gender and race/ethnicity; Analysis to identify sociodemographic, social, and mental health correlates of obesity.

Monitoring: Follow-up the development and implementation of SPAN.

Activity 2: Implement a pediatric obesity program targeting children ages 2-12 years to decrease the prevalence of adolescent obesity in the state of Texas.

Output Measure: Number of children served; number of children referred to the program; number of outreach activities; number of contractors providing services.

Monitoring: Review of quarterly progress reports.

Activity 3: Work with DSHS Division of School Health to disseminate information and resources about the prevalence and risk factors associated with adolescent obesity to school administrators, teachers, school nurses, parents and students.

Output Measure: Number, type and format of materials provided.

Monitoring: Copy of materials, products, or resources provided; summary of annual activities.

Activity 4: Coordinate healthy living activities (i.e. healthy eating, physical activities) targeted to at-risk adolescents with internal and external stakeholders.

Output Measure: Number, type and format of activities implemented.

Monitoring: Copy of materials or products distributed; summary of annual activities.

State Performance Measure 6: *The percent of children provided preventive dental services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				42	42.5
Annual Indicator			41.5	40.0	42.1
Numerator			1051633	1047804	1112410
Denominator			2532422	2620912	2642556
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	43	43.5	44	44.5	45

Notes - 2007

Source: TMHP, HISR303A, AHMST069, SFY 2007.

Notes - 2006

Source: TMHP, HISR303A, SFY 2006 Final (AHMST081).

Notes - 2005

Source: TMHP, HISR303A, SFY 2005 Final (AHMST081).

Data are for the State Fiscal Year (September - August).

Preventive services include all ADA preventive codes, D1000-D1999.

a. Last Year's Accomplishments

Activity 1: Provide dental services to third graders across the state enrolled in the free and reduced lunch program.

Update: During FY2007, dental sealants were provided to 6,047 third graders through the direct efforts of the DSHS regional dental teams and/or through collaborations between the DSHS regional dental teams and community-based and/or dental academic based affiliations. In addition, DSHS contractors who provide Title V-funded dental care served 9,430 clients under age 21.

Activity 2: Continue to support a state oral health coalition/collaboration to promote oral health prevention through water fluoridation and dental sealants.

Update: DSHS continues to support the Texas Oral Health Coalition (TxOHC), which completed its third year as a formal coalition during FY2007. The TxOHC is made up of approximately 40 members from public health agencies, academic institutions, professionals associations, and community based organizations. TxOHC members were actively involved with oral health prevention through community water fluoridation activities to include: grassroots advocacy within

communities where fluoridation has been discontinued and/or in areas that are currently non-fluoridated. The Texas Fluoridation Project (TFP) Engineer has worked closely with the coalition to increase awareness of the benefits of community water fluoridation, and the cost associated with fluoridating water systems. Currently, 78.2% of Texans have fluoridated water, leaving about 4.7 million people without fluoridated water. TFP has developed a booklet about water fluoridation procedures and has designed bilingual posters for fluoridation promotion to increase awareness and collaborative support from the coalition. TxOHC members are promoting oral health prevention activities (fluoride and dental sealant projects), through their regional oral health coalition programs.

Activity 3: Continue providing training to local water system operators, on-site inspections of system/equipment needs, and technical assistance to communities in need of fluoridation systems or upgrades.

Update: During FY2007, the Texas Fluoridation Project (TFP) staff conducted 56 site inspections of public water systems that fluoridate during which technical assistance was provided as needed. TFP held four training classes in Beaumont, Athens, Lewisville, and Texas City for water works operators with 39 water operators in attendance.

Activity 4: Collaborate with multiple stakeholders to develop activities and materials to promote the dental home concept and early intervention to both providers and recipients of services.

Update: DSHS Oral Health Program staff has worked with various partners including the Texas Dental Association, the Texas Academy of Pediatric Dentists, the Texas Dental Hygienists' Association, the Texas State Head Start Collaboration Office, and the Administration for Children and Families Region VI staff to develop pilot activities to promote early intervention and the establishment of a dental home for children. As a result of various collaborations, activities and materials to promote the dental home concept and early intervention for use by providers and recipients of services were developed. Two online continuing education modules -- Dental Health For Primary Care Providers and Dental Screening by Dental Professionals -- were completed and posted online (<http://txhealthsteps.com>).

Performance Assessment: Approximately 40% of all children received dental sealants in 2006. Increases in the reimbursement rates and new dental home initiatives implemented throughout Texas may contribute to the achievement of the performance objective. However, additional time will be required before assessing the impact of these initiatives.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide dental services to third graders across the state enrolled in the free and reduced lunch program.			X	
2. Continue to support a state oral health coalition/collaboration to promote oral health prevention through water fluoridation and dental sealants.				X
3. Continue providing training to local water system operators, on-site inspections of system/equipment needs, and technical assistance to communities in need of fluoridation systems or upgrades.			X	
4. Collaborate with multiple stakeholders to develop activities and materials to promote the dental home concept and early intervention to both providers and recipients of services.				X
5.				
6.				

7.				
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10.				

b. Current Activities

Activity 1: A total of 5,891 children have received preventive dental services during the first two quarters of FY08. The DSHS OHP provides preventive dental services to preschool and elementary school children, not just third graders. Therefore we are reporting on the total number of children receiving preventive services, as stipulated in the output measure, not just third graders. In addition, DSHS contractors who provide Title V-funded dental care served 3,407 clients under age 21.

Activity 2: The TxOHC held a general meeting on Friday, January 25, 2008, in Austin, with approximately 30 members in attendance. The TxOHC decided to go through a strategic planning process at their April meeting, utilizing a facilitator. DSHS will assist TxOHC by providing the facilitator and continues to assist TxOHC by arranging for meeting facilities.

Activity 3: The DSHS Texas Fluoridation Project continues to support Texas communities in their water fluoridation efforts through the provision of technical assistance, water operator training, inspections of water fluoridation equipment, and distribution of water fluoridation education materials. All of these activities are on-going.

Activity 4: The First Dental Home strategic initiative workgroup finalized the anticipatory guidance, visit documentation, and parent education materials. These materials will be utilized beginning in March 2008 with the roll out of the First Dental Home initiative.

c. Plan for the Coming Year

Activity 1: Provide dental services to third graders across the state enrolled in the free and reduced lunch program.

Output Measure(s): Number of children served by regional dental teams or other entities.

Monitoring: Review and analysis of oral health data reports and screening survey reports.

Activity 2: Continue to support collaborations to promote oral health prevention through water fluoridation and dental sealants.

Output Measure(s): Number and types collaborative activities to promote oral health including preventive dental services.

Monitoring: Review and track progress through semi-annual activity reports of the OHP.

Activity 3: Continue providing training to local water system operators, on-site inspections of system/equipment needs, and technical assistance to communities in need of fluoridation systems or upgrades.

Output Measure(s): Number of training classes, on-site inspections, and technical assistance provided.

Monitoring: Review of and track progress through program quarterly activity reports and make necessary adjustments to the yearly plan.

Activity 4: Collaborate with multiple stakeholders to develop activities and materials to promote the dental home concept and early intervention to both providers and recipients of services.

Output Measure: Number and type of stakeholders involved in developing activities, number of meetings held, and number and type of tangible products developed.

Monitoring: Documentation of meetings held and brochures, posters and other materials developed and distributed.

State Performance Measure 7: Rate of family violence incidents involving females victims per 1,000 women in Texas

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				11.9	11.7
Annual Indicator			13.1	13.0	13.1
Numerator			149681	152549	155472
Denominator			11440521	11754567	11849105
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	11.5	11.3	11.1	11.1	11.1

Notes - 2007

Numerator Source: <http://www.txdps.state.tx.us/crimereports/06/citi04ch5pdf> from the Texas Department of Public Safety.

Data presents a projected linear trend for 2007 based on data from 2005 and 2006.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

Notes - 2006

Numerator Source: <http://www.txdps.state.tx.us/crimereports/06/citi04ch5pdf> from the Texas Department of Public Safety.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

Notes - 2005

Numerator Source: <http://www.txdps.state.tx.us/crimereports/05/citi04ch5pdf> from the Texas Department of Public Safety.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>).

a. Last Year's Accomplishments

Activity 1: Increase the number of successful referrals that occur as a result of screening for abuse in the Pregnant and Post-Partum Intervention Programs (PPI).

Update: Work continued on the design of Pregnant and Post-Partum Intervention Program (PPI) - specific module with the goal of implementing it in FY 2008.

Activity 2: Collaborate with the Office of the Attorney General on a proposed cooperative agreement with the Centers for Disease Control and Prevention (CDC) to develop a Sexual Violence Prevention and Education program.

Update: Title V staff attended four planning meetings to insure ongoing collaboration with the Office of the Attorney General and attended the three Primary Prevention Planning Committee (PPPC) meetings held in FY2007. Staff worked with a subcommittee of the PPPC to develop a web-based survey to gain a better understanding of current practices and resources for primary prevention at the local level. This survey will be implemented in the summer of 2007. The Title V Child Health Coordinator also serves on the steering committee for the Interpersonal Violence Prevention Collaborative (IVPC), a multi-agency effort to network, share resources and promote activities that will reduce interpersonal violence in Texas. This group has met approximately five times in FY2007.

Activity 3: Estimate prevalence of family violence during and one year following pregnancy by integrating data from the Department of Public Safety and Vital Statistics.

Update: While this activity was not completed in FY07, significant progress was made that will help to ensure future completion. In FY07, the SSDI Governance Committee was established to facilitate data linkages. A representative from the Department of Public Safety is on the Governance Committee. Title V staff responsible for the SSDI grant planned to work with the Department of Public Safety representative to determine the necessary steps to complete this activity.

Performance Assessment: The rate of family violence has remained relatively constant in Texas over the past three reporting years. The Title V Program will continue to focus on opportunities to provide education about preventing and recognizing domestic violence and partnerships with internal and external stakeholders to promote a more multifaceted approach to reducing this indicator. Increased collaboration between Title V and the Texas Office of the Attorney General may strengthen existing programs to reduce family and other kinds of violence.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase the number of successful referrals that occur as a result of screening for abuse in the Pregnant and Post-Partum Intervention Programs (PPI).			X	X
2. Collaborate with the Office of the Attorney General on a proposed cooperative agreement with the Centers for Disease Control and Prevention (CDC) to develop a Sexual Violence Prevention and Education program.				X
3. Integrate family violence prevention professionals into State Child Fatality Review Team and local Child Fatality Review Teams.				X
4. Participate on the Interpersonal Violence Prevention Collaborative steering committee.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: During Q1 and Q2 of FY08, approximately 1,945 women were screened for abuse using the PPI risk assessment tool. Due to limited staff resources, no data are currently available on the number of women who answered yes to the question of abuse, however in an effort to reach women experiencing abuse, PPI program staff have begun outreaching to local family

violence shelters.

Activity 2: One Rape Prevention and Education (RPE) planning committee meeting has been held during FY08 and was attended by Title V staff. Title V staff is currently chairing a committee to determine the capacity of the state to do primary prevention of sexual violence. A survey was sent to RPE-funded agencies during late FY07 and is currently being evaluated. A survey for community organizations and agencies across Texas was sent out February 1st.

Activity 3: The 2007 CFRT Report is currently being updated and includes recommendations to the Texas Legislature to add a statute requiring the presence of a family violence prevention professional to SCFRT.

Activity 4: One IVPC meeting has been held during FY08. The IVPC committee is currently working on the development of an IVPC logo.

c. Plan for the Coming Year

Activity 1: Increase opportunities for family violence prevention activities at the state and local level.

Output Measure(s): Number and type of family violence prevention activities facilitated, Number and type of materials disseminated, number of IVPC meetings attended and description of activities.

Monitoring: Quarterly ESC reports, copies of distributed materials, meeting minutes.

Activity 2: Collaborate with the Office of the Attorney General on activities in conjunction with the RPE grant from the Centers for Disease Control and Prevention (CDC).

Output Measure(s): Number of sexual violence prevention planning committee meetings attended by Title V staff and summary of committee and primary prevention activities.

Monitoring: Minutes from quarterly sexual violence prevention planning committee meetings. Data reports.

Activity 3: Integrate family violence prevention professionals into State Child Fatality Review Team (SCFRT) and local Child Fatality Review Teams.

Output Measure(s): Number of teams that include a family violence prevention professional; addition of family violence prevention professional to SCFRT as an ad hoc member.

Monitoring: Quarterly membership rosters.

Activity 4: Participate on the Interpersonal Violence Prevention Collaborative steering committee.

Output Measure(s): Number of meetings attended; implemented activities.

Monitoring: Meeting minutes.

E. Health Status Indicators

Second in size among the states, Texas has a land and water area of 268,581 square miles as compared with Alaska's 663,267 square miles. California, third largest state, has 163,696 square

miles. Texas is as large as all of New England, New York, Pennsylvania, Ohio and North Carolina combined. Racially, Texas is primarily White with almost 7 times more Whites than African Americans. Ethnically, Texas has a significant Hispanic or Latino population. Among children 0 through 24 years of age, those of Hispanic or Latino descent accounted for 43% of the population.

/2008/ Among children 0 through 24 years of age, those of Hispanic or Latino descent accounted for 44% of the population. //2008//

/2009/ While children ages 0 to 24 years continue to comprise 44% of the Texas population, among children 1 to 4 years of age there is a nearly even split between Hispanic or Latino children and non Hispanic and non Latino children. Hispanic or Latino infants comprised more than half of all infants. //2009//

Of the 50 largest cities in the country, 3 of the top 10 and 6 of the top 20 are located in Texas. This accounts for the more than 5 million children ages 0 through 19 who reside in urban areas. Almost 1.2 million Texas children ages 0 to 19 reside in rural areas with an additional 64,305 residing in frontier areas.

/2008/ More than 1.2 million children ages 0 to 19 years reside in rural areas with an additional 63,798 residing in frontier areas. //2008//

Proportions of residents living in poverty were greater among children 0 through 19 years of age than in the population in general. In the population, 36% of Texas residents are within 200% of poverty compared to 46% of children 0 through 19 years of age. Similar disparities were found for 50% of poverty and 100% of poverty.

Racially, the greatest number of births is to White mothers with nearly 10 times as many births as African Americans. Ethnically, Hispanic or Latino mothers account for slightly more than half (50.3%) of all births in Texas. Provisional data for 2005 projects continued consistency for several measures of birth outcome. In 2001, low birth weight among singletons was 6.1% with a projection for 2005 of 6.3%. The low birth weight rate in Texas is approximately 25% higher than the Healthy People 2010 objective of 5.0%. Very low birth weight has had similar consistency. Among singleton births in 2001, 1.0% had birth weight of less than 1,500 grams with a projection of 1.1% by 2005. The 2005 very low birth weight rate also is approximately 20% higher than the Health People 2010 Objective of 0.9%. Movement in this indicator contributes the monitoring of the impact of the 17 3-year population based contracts awarded in FY06 and FY07. While some of these contracts directly address low birth weight, the other topic areas addressed -- teen pregnancy, adequacy of prenatal care, and sexually transmitted diseases -- all contribute to low birth weight. Collaborations with March of Dimes (MOD) may also help to move this indicator. DSHS has used data from the Texas Pregnancy Risk Assessment Monitoring System (PRAMS) to inform the development of programs to improve birth outcomes among African Americans.

/2008/ The number of births to White mothers is approximately 8 times the number of births to African American mothers. Low birth weight among singletons is projected to be 6.4% in 2006, which is 28% higher than the Healthy People 2010 objective of 5%. Very low birth weight among singletons is projected to be 1.1% in 2006, which is 22% higher than the Healthy People 2010 objective of 0.9%.//2008//

/2009/ Since 2000, there has been a small, but steady increase in the percent of children born weighing less than 2,500 grams. This has continued through 2004 and in projections for 2005 through 2007. A similar pattern was found for very low birth weight though beginning in 2001. Increasing access to prenatal care through CHIP Perinatal and developing strategies to increase the number of high risk deliveries receiving care in appropriate environments may help to reduce the proportions of low and very low birth weight. The Texas Title V Program has also partnered with the Texas March of Dimes on a

faith-based prenatal education program targeting African American women that provides education and social support. Further analysis is needed to determine the impact of new assisted reproductive technology on birth weight outcomes. //2009//

Mortality rates due to unintentional injuries among children aged 14 years and younger are projected to decline in 2005 to 9.7 deaths per 100,000 children aged 14 years and younger. This would be a decline of 11% from the 10.9 deaths per 100,000 in 2001. Mortality rates due to motor vehicle crashes remained steady between 2001 and 2005. The projected rate in 2005 is 5.0 deaths per 100,000 children aged 14 years and younger. This projected rate would be 7.4% less than the rate of 5.4 deaths per 100,000 children aged 14 years and younger in 2001. While also consistent between 2001 and 2005, the mortality rate due to motor vehicle crashes was approximately 6 times greater in 15 through 24 year olds as compared to children aged 14 years and younger. The projected mortality rate due to motor vehicle crashes among youth 15 through 24 years old is 31.2 deaths per 100,000 youth ages 15 to 24 years, which is similar to the mortality rate of 31.1 deaths per 100,000 youth ages 15 to 24 years in 2001. With responsibility for the operations of the State Child Fatality Review Committee transferred to the Title V Office, assessment of data will be ongoing and findings expeditiously translated into prevention activities. This process may result in changes in these indicators.

*//2008/*In 2006, projected mortality due to unintentional injury decreased to 9.4 deaths per 100,000 children ages 14 years and younger; an almost 14% decline from 2001. The projected rate of mortality due to motor vehicle crashes declined slightly in 2006 to 4.9 deaths per 100,000 children aged 14 years and younger, a 9% decline from 2001. In 2006, the projected mortality rate due to motor vehicle crashes among youth 15 to 24 years old is 31.2 deaths per 100,000.*//2008//*

Rates of nonfatal injuries among children aged 14 years and younger have been inconsistent between 2001 through 2005. The 2005 rate of 234.7 nonfatal injuries per 100,000 children aged 14 years and younger is similar to the 2002 rate 226.7 nonfatal injuries per 100,000 children aged 14 years and younger, but substantially higher than the rates in 2003, 182.3 nonfatal injuries per 100,000 children aged 14 years and younger, and 2004, 174.2 nonfatal injuries per 100,000 children aged 14 years and younger. The nonfatal injury rate due to motor vehicle crashes in 2005 of 54.8 nonfatal injuries due to motor vehicle crashes per 100,000 children aged 14 years and younger was lower than rates in 2003 (74.2 per 100,000) and 2004 (63.9 per 100,000), but greater than rates in 2002 of 35.4 nonfatal injuries due to motor vehicle crashes per 100,000 children aged 14 years and younger. The rate of nonfatal injuries due to motor vehicle crashes per 100,000 were significantly higher among youth aged 15 to 24 years than children 14 years and younger. Among youth ages 15 to 24 years, the rate of nonfatal injuries due to motor vehicle crashes is 209.2 per 100,000, four times greater than among children 14 years and younger. The rate in 2005 was the lowest since 2003. Between 2003 and 2004, the rate of nonfatal injuries due to motor vehicle crashes doubled to 224.4 per 100,000 and has continued to exceed 200 per 100,000. To improve this indicator, the Title V Office will conduct analyses of the Texas Hospital Discharge Data to identify trends in nonfatal injuries, compare these to mortality trends, and inform programmatic activities pertaining to prevention.

//2008/ Rates of non-fatal injuries in 2006 were higher than any rate reported in the past 5 years (240.8 nonfatal injuries per 100,000 children ages 14 years and younger). The nonfatal injury rate due to motor vehicle crashes in 2006 of 53.5 per 100,000 children ages 14 years and younger was the lowest since 2002. Among youth ages 15 to 24 years, the rate of nonfatal injuries due to motor vehicle crashes is 175.5 per 100,000, three times greater than among children 14 years and younger. The rate in 2006 was the first time this indicator was below 200 deaths per 100,000 since 2002. *//2008//*

//2009/ Death due to unintentional injury among children under 14 years of age and death rates due to unintentional injury among children under 14 years of age due to motor vehicle crashes continued to decline through 2007. However, nonfatal injuries for both groups have increased.

The death rate due to unintentional injury among youth 15 to 24 years of age has increased in 2006 and 2007. However, the rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years decreased nearly 25% from 2003 to 172.9 per 100,000.

The Texas Title V Program is continuing to explore methods for reducing injury, both fatal and nonfatal. Increased visibility and attendance at the annual Child Fatality Review Conference has increased training and learning opportunities throughout Texas and the annual Child Fatality Review Report has provided a good source of data for local teams. Increased activity by local fatality review teams may contribute to improvements in these indicators. //2009//

Chlamydia rates have declined since 2001 among women ages 15 through 19 years, but have increased slightly among women 20 through 44 years during the same time period. In 2001, the rate of chlamydia among women ages 15 through 19 years was 29.0 cases per 1,000 which decreased to 25.8 cases per 1,000 in 2005. In 2004, the most recent year for which national surveillance data are available, Texas had a lower rate of chlamydia among women ages 15 through 19 years (26.2 cases per 1,000) than there was nationally (27.6 cases per 1,000). Among women ages 20 through 44 in Texas, rates of chlamydia ranged between 8.0 cases per 1,000 women ages 20 through 44 in 2001 to 8.5 cases per 1,000. The rate of chlamydia in Texas in 2004 (8.3 cases per 1,000) was higher than the national rate in the same age group (8.1 cases per 1,000).

/2008/ The rate of chlamydia infection among women ages 15 to 19 are projected to decline to 25.4 cases per 1,000 by 2006. For women 20 to 44 years of age, the projected rate in 2006 is the same as 2005 (8.5 cases per 1,000). //2008//

//2009/ Chlamydia rates have declined among women ages 15 to 19 years, but has remained steady among women ages 20 to 44 years. Title V intervention to reduce adolescent pregnancy rates and increased attention to positive health messages to women in the preconception period may contribute to additional reductions among women ages 15 to 19 and begin declines in adult women of childbearing age. //2009//

F. Other Program Activities

Sudden Infant Death Syndrome (SIDS): The Title V Program administers an autopsy reimbursement program mandated by Texas statute that allows counties to claim a fixed reimbursement toward the cost of an autopsy where the cause of death is determined to be SIDS. The program also provides a mechanism to track SIDS deaths, maintain a database that includes demographic information on the case and develop a better understanding of the circumstances that surround SIDS. In FY 03, Title V staff worked with a state-level workgroup to develop and present a workshop on infant mortality. A possible future activity for Title V staff is training stakeholders from areas with the highest incidence of SIDS.

Child Fatality Review: Texas has 46 local child fatality review teams (CFRTs) that review child deaths, identify gaps in service and agency coordination and develop community programs and activities to reduce the incidence of preventable child deaths. Data are collected and sent to DSHS for analysis, and aggregated data are used to identify statewide trends and prevention strategies likely to reduce preventable child deaths.

The Texas CFRT State Committee is charged with developing a better understanding of the causes and incidence of child deaths, promoting public awareness, making recommendations for changes in law, policy, and practices in order to reduce the number of preventable child deaths, and supporting the local CFRTs through technical assistance and networking. DSHS and the Department of Family and Protective Services (DFPS) jointly lead the State Committee.

Legislation that passed during the 79th Texas Legislature moves the Committee leadership to DSHS. The feasibility of placing the Committee in the Title V program is being considered.

During the 79th Texas Legislature, there were discussions on creating a Fetal-Infant Mortality Review (FIMR) process. While the legislation did not pass, it is clear that information gained from a thorough, competent FIMR process enhances understanding of fetal and infant mortality and child deaths. DSHS staff are also looking at opportunities to integrate the FIMR process into the CFRT structure.

Toll-Free Hotline-2-1-1 Texas (2-1-1): As part of the HB 2292 Consolidation Act, many local and statewide health and human services toll free hotlines in Texas were centralized. The purpose was to minimize duplication, facilitate accessing information for the consumer, standardize the content and quality of the information provided, and reduce costs. Previously, Title V had multiple toll-free lines based on the various program areas including the Family Health Services toll-free line. In November 2004, most of the services provided by the Family Health Services toll-free hotline were transferred to 2-1-1 to provide callers with information about services offered by nonprofit and faith-based organizations and government agencies. The centralization of these lines enables consumers to easily access information. The service is provided through a public/private collaboration of the United Way and other community-based organizations and the Texas Health and Human Services Commission (HHSC). The state is divided into 25 Area Information Centers (AICs) that are networked to enable access to each other and to allow higher volume AICs to take calls for lower volume AICs as needed. The whole system can also mobilized to provide information and updates during times of emergency or during significant public health events.

//2007//The responsibility for Child Fatality Review was officially integrated into the Title V Office in 2006, giving Title V staff the coordinating role for a group that can impact policies to reduce infant and child deaths. Due to the wide level of multidisciplinary stakeholder involvement from the CFRTs, DSHS gains extensive statewide information and support through this function.//2007//

The 2-1-1 line is available 24 hours a day, seven days a week and is accessible in multiple languages and by text telephone, or TTY. The language services are provided either by Tele-Interpreter or the AT&T Language Line. Title V and other DSHS staff routinely provide referral sources, such as contractors, to update the 2-1-1 database.

Referrals provided through 2-1-1 include assistance programs such as Medicaid, Medical Transportation, Food Stamps, TANF, WIC, Title V and other social services; service providers, including Early Childhood Intervention, immunization, substance abuse, mental illness, and mental retardation; Texas Special Education information; job training for persons with disabilities through the Texas Rehabilitation Commission; referral to licensed child-care facilities; resources for food, clothing, housing, education; and parenting classes.

As part of the transition, DSHS staff met with HHSC and 2-1-1 staff to review the capacity of 2-1-1. The decision was to continue a toll-free DSHS line so 2-1-1 could refer certain types of calls to DSHS. These calls include health screening programs and CSHCN.

From September to November 2004, 2,028 calls were received and 2,571 referrals were made through the Family Health Services line. After that, 2-1-1 became responsible for data collection. From December 2004 to May 2005, 2-1-1 handled 39,377 maternal and child health-related calls. The highest number of referrals was for medical expense assistance, followed by dental care and outpatient mental health care. This increase may be due to the simplicity of the number, the multi-lingual capacity, and the broader array of information and referral sources. The 2-1-1 System is growing through software enhancement and expanded data collection capabilities. Title V and 2-1-1 staff have collaborated to assure that Title V needs assessment data are routinely collected. //2007// Ultimately, 2-1-1 handled 60,755 maternal and child-health related calls in FY2005. In the first half of FY2006, 2-1-1 handled 50,281 maternal and child-health related calls. To date in

FY2006, the highest number of referrals was for medical expense assistance, followed by immunizations, dental care, outpatient mental health and local transportation.//2007//

National Women's Health Week (NWHW): Title V staff promoted the 2005 NWHW by informing contractors of the opportunity to develop activities focusing on women's health and serving as a resource for those who participated. Title V staff also worked with the Cardiovascular Health and Wellness Program to present an activity at DSHS. /2007/ Title V staff coordinated NWHW again in 2006.//2007//

/2008/In 2007, the Women's Health Program began providing reproductive and women's health services to low-income women through a Medicaid waiver. Women who are citizens (or eligible immigrants) between the ages of 18 and 44, and who have a net income at or below 185% FPL can become eligible for the program. From January to April of this year, there were over 60,000 applications submitted and monthly enrollment figures have averaged nearly 39,000. DSHS staff continue to work with HHSC staff and DSHS contractors to provide outreach and referrals. Title V funds are used to serve women who are ineligible because of citizenship or who are under 18.//2008//

/2009/ For calendar year 2007, WHP provided client services to 56,181 clients or 67% of those who completed enrollment. In the first year, it has expanded access to family planning services for uninsured women across the state. In October of 2007, Texas received approval to amend the waiver allow for additional screening tests, including cholesterol, tuberculosis, and confirmatory HIV tests. DSHS FCHS staff continued to work with HHSC to coordinate women's health activities related to the waiver. The success of WHP has raised some challenges related to the capacity of Title V and XX providers. In FY07 and FY08, there appear to be a reduction in the numbers of women served and FCHS continues to work with providers to explore means of expanding capacity.//2009//

G. Technical Assistance

The population diversity, economy, and health needs of Texas continue to evolve in an environment for which resources continue to diminish, requiring an infrastructure that is effective and efficient. Consideration of the technical assistance needs described on Form 15 will enhance the state Title V program's efforts to meet the challenge of improving the health of the MCH population. Form 15 identifies the key areas for which Texas is requesting technical assistance.

Item 1 is related to NPM 9 for oral health. While nationally there is increasing recognition of the importance of early screening and referral for preventive care in the oral health of children, there remains a need to enhance access to such care. Currently, a limited number of pediatric and general dentists possesses the background and training to offer and/or provide this service. In Texas, practicing pediatric dentists are small in number and are concentrated in a limited number of urban counties. In order to meet the needs of young children, Texas requests technical assistance and funding to identify best practices related to providing and promoting preventive oral health care, including sealants, for children under 5, a plan for implementing training for providers on oral health screening/care to young children as well as enhancing awareness of caregivers regarding the importance of early preventive oral health care.

Items 2 and 3 are related to NPM 15, low birth weight infants and NPM 18, early prenatal care, specifically for the significant disparities that continue to exist for African American women. Although the Title V program activity plan for FY06 will target the population and areas of the state where low birth weights and low utilization of early prenatal care exist, Texas would benefit from technical assistance to identify low-cost yet effective strategies that would positively impact these two national measures and ultimately the outcome measures that continue to be a challenge. Those outcomes measures are infant mortality (OM #1), neonatal mortality (OM #3), perinatal mortality (OM #5), and, specifically related to the African American health disparity, the ratios of black infant mortality (OM #2) and perinatal infant mortality (OM #7) to that of whites.

Texas data for these disparities mirror national data but there is no clear explanation for the disparities. However, research indicates that although early and adequate prenatal care is the primary approach to resolve the disparity, strategies designed to enroll and provide the care must meet the specific needs of the target population. Life Course Perspective is an evidence-based intervention model that specifically addresses this disparity by focusing on the overall health status of women, with special emphasis on the critical factors of inflammation, infection and stress. With technical assistance to design and implement this type of model, the Texas Title V program may be able to positively impact the health disparities in low birth weights and prenatal care for African American women.

Item 4 relates to improving the Texas Immunization Program's technical assistance materials and methods. Improvement in this infrastructure could positively impact immunization rates in Texas (NPM 7) and ultimately all of the national and state outcome measures. The DSHS Immunization Program requests assistance in use of the program website as an effective technical assistance tool; for an external evaluation of customer service provision through the DSHS central office, the DSHS health service regions, and local health departments; and an external evaluation of publications used to provide technical assistance to the public, to healthcare providers, and to contractors around the state.

Item 5 is related to NPM 1 for newborn screening expansion. Pursuant to Legislation (House Bill 790) passed in the recently completed 79th Legislative Regular Session, DSHS will be looking to expand the panel of inheritable disorders screened in Texas. While expanding the screening, Texas also needs to consider the establishment of regionally-based contracts to assist with the follow-up, confirmatory testing and treatment of children who screen initially positive for the expanded list of disorders. Literature reviews indicate that often Title V is a source of additional funding to enhance newborn screening programs across the nation (Financing State Newborn Screening Systems in an Era of Change, Association of State and Territorial Health Officials, March 2005). Texas requests technical assistance resources to determine the feasibility of establishing regionally-based providers, educating them on the expanded disorders, and funding the follow-up, confirmatory testing and treatment of identified children in Texas.

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ratios of black infant mortality (OM #2) and perinatal infant mortality (OM #7) to that of Whites. Texas data for these disparities mirror national data but there is no clear explanation for the disparities. However, research indicates that although early and adequate prenatal care is the primary approach to resolve the disparity, strategies designed to enroll and provide the care must meet the specific needs of the target population. Life Course Perspective is an evidence-based intervention model that specifically addresses this disparity by focusing on the overall health status of women, with special emphasis on the critical factors of inflammation, infection and stress. With technical assistance to design and implement this type of model, the Texas Title V program may be able to positively impact the health disparities in low birth weights and prenatal care for African American women.

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Item 5 relates to infrastructure improvements through increased public health and non profit leadership skills. Texas is currently one of the only states that does not have a public health leadership institute and is without access to a regional public health leadership institute. The creation of a Texas Public Health Leadership Institute would have two goals: 1) to enhance the leadership skills and abilities of senior and mid-level managers in state, regional, and local public health agencies and 2) to form a network of public health leaders in Texas and within Texas' public health regions. A Texas Public Health Leadership Institute would support the strengthening of leadership competencies, such as creating a shared vision, personal awareness, systems thinking, risk communication, team building, ethical decision making and political and social change strategies, which could contribute to improving the health of Texans through improved service delivery, efficiency, and strategic planning. Texas requests technical assistance resources to determine the feasibility and implementation plan of establishing a unique Texas resource for public health leadership development. //2007//

/2008/ There is a continued effort within the oral health program to seek out innovative practices that can be used to highlight the importance of early screening and referral for preventive care in the oral health of children. Texas continues to search for best practices related to providing and promoting preventive oral health care, including sealants for children under five; training options for providers on oral health screening/care for young children; and means of enhancing awareness of caregivers regarding the importance of early preventive oral health care.//2008//

/2008/In order to respond to direction to develop and fill a state position of parent consultant that must be filled by a parent or family member of a CSHCN, Title V staff are seeking an analysis of other states' policies and procedures related to similar positions and the corresponding employment criteria.//2008//

/2009/ There are two areas in which Texas will seek technical assistance in FY09. First, leaders within DSHS continue to identify and support efforts to integrate behavioral and physical health systems across programs. The Office of Title V and Family Health will seek suggestions regarding best practices and other innovative alternatives involving Title V programs in other states.

The second issue will be focused on efforts related to injury and violence prevention activities for the MCH population. DSHS will receive the benefits of a State Technical Assessment Team visit from the State & Territorial Injury Prevention Directors Association

in September 2008. The Office of Title V and Family Health will review the recommendations made by the team and seek technical assistance regarding opportunities to develop MCH preventive services. //2009//

V. Budget Narrative

A. Expenditures

Forms 3, 4, and 5 show variations in expenditure amounts, which could be explained by the Title V budget realignment conducted for FY 02 and FY 03, directives from recent legislative sessions, the impact of CHIP, and the re-directing of Title V funds to accommodate specific MCH population needs.

Form 3 shows a variation in expenditures between FY 01 and FY 04. The expenditure level decreased from \$107,287,294 in FY 01 to \$85,078,798 in FY 04, representing about 21% variation. A portion of this decrease is attributed to a reduction in Title V state funds by an estimated of \$7.8 million and \$4.5 million in FY 02 and FY 03, respectively. This budget realignment effort was necessary because the Title V MCH program budgeted for services over and above the annual state and federal appropriations for some time. In addition, the 77th Legislative Session mandated Title V MCH and CSHCN programs to transfer state general revenue funds to CHIP and the Interagency Council on Early Childhood Intervention.

Form 3 also shows a carryforward of about \$10 million from FY 05 into FY 06. One of many contributing factors could be the impact of CHIP. Expenditures on children between the ages of 1 and 22 vary greatly from \$26,149,744 in FY 01 to \$18,467,367 in FY04. Title V-funded contractors are required to screen children for potential Medicaid and CHIP eligibility prior to determining Title V eligibility and to spend at least 25% of their Title V amounts on children. Many of the contractors are experiencing difficulties in achieving the 25% requirement because a number of children who used to receive Title V child health services currently are covered by CHIP.

In addition, this carryforward could not be used alone to remove additional children from the CSHCN waiting list since this funding is available only one time. In other words, the CSHCN program could not sustain similar capacity to cover expenditures for all these children beyond FY 05. Another contributing factor is that the CSHCN program must notify the Legislative Budget Board and Governor at least 30 days prior to adding clients from the waiting lists to the program rolls. This mandated procedure has caused delays in moving children from the waiting list. Fortunately, the recently completed 79th Legislative Regular Session has changed the 30-day notification to 15 days, effective September 1, 2005.

The characteristics of the population served by the CSHSCN program contribute greatly in the significant variations in client expenditures from year to year. DSHS regularly analyzes the CSHCN Program client expenditures to operate within budget limitations. In FY 04, projected expenditures based on historical utilization data were greater than incurred costs to the state. As appropriate, funds were carried forward to FY 05 to allow additional children to be removed from the existing waiting list for the CSHCN Services Program's health care benefits. Projected costs vary due to differences in client access and utilization of third party coverage (i.e., Titles XIX, XXI, or private insurance); the wide array of possible diagnoses allowed within the eligibility criteria; and the unique medical needs of children with similar diagnoses.

Form 4 shows variations in the expenditures across MCH population types. Pregnant women, as well as infants under 1 year old, remain stable between FY 01 and FY 04. The expenditure levels between FY 01 and FY 04 are \$ 18.1 million and \$17.4 for pregnant women, and \$188,643 and \$170,750 for infants under 1 year old. These slight variations in expenditures for pregnant women and infants less than 1 year old can be attributed to the FY 02 & FY 03 Title V budget realignment.

Expenditures for CSHCN decreased from \$41,346,111 in FY 01 to \$29,608,981 in FY 04. This decrease can be attributed to two main raisons: 1) Title V was asked by the 77th Legislative Session to transfer one-time only \$7 million in Title V funds to the Interagency Council on Early

Childhood Intervention (ECI), which provides a coordinated system of services available in every Texas county for children, birth through age 3, with disabilities or delays; and 2) CSHCN program was mandated by the same legislative session to commit state general revenues funds of \$3 million in FY 02 and \$10 million in FY 03 as savings acquired due to CSHCN being covered by CHIP and Medicaid programs.

Form 5 indicates significant variation in expenditures by types of service. As result of the decrease in total expenditures of \$107,287,294 in FY 01 to \$85,078,796 in FY 04, every category (i.e., direct health care services, enabling services, population-based services, and infrastructure building services) experienced decreases in expenditures. The rationale behind these expenditure variations was addressed in Forms 3 & 4 budget justifications.

/2007/ Forms 3, 4, and 5 show variations in expenditure amounts, which could be explained by the Title V budget realignment conducted for FY 02 and FY 03, directives from recent legislative sessions, the impact of CHIP, and the re-directing of Title V funds to accommodate specific MCH population needs.

Form 3 shows a variation in expenditures between FY 01 and FY 05. The expenditure level decreased from \$107,287,294 in FY 01 to \$83,872,474 in FY 05, representing about 22% variation. A portion of this decrease is attributed to a reduction in Title V state funds by an estimated of \$7.8 million and \$4.5 million in FY 02 and FY 03, respectively. This budget realignment effort was necessary because the Title V MCH program budgeted for services over and above the annual state and federal appropriations for some time. In addition, the 77th Legislative Session mandated Title V MCH and CSHCN programs to transfer state general revenue funds to CHIP and the Interagency Council on Early Childhood Intervention.

Form 3 also shows a carryforward of about \$10.5 million from FY 06 into FY 07. One of many contributing factors could be the impact of CHIP. Expenditures on children between the ages of 1 and 22 vary greatly from \$26,149,744 in FY 01 to \$18,513,536 in FY05. Title V-funded contractors are required to screen children for potential Medicaid and CHIP eligibility prior to determining Title V eligibility and to spend at least 25% of their Title V amounts on children. Many of the contractors are experiencing difficulties in achieving the 25% requirement because a number of children who used to receive Title V child health services currently are covered by CHIP.

In addition, this carryforward could not be used alone to remove additional children from the CSHCN waiting list since this funding is available only one time. In other words, the CSHCN program could not sustain similar capacity to cover expenditures for all these children beyond FY 05. Another contributing factor is that the CSHCN program must notify the Legislative Budget Board and Governor at least 30 days prior to adding clients from the waiting lists to the program rolls. This mandated procedure has caused delays in moving children from the waiting list. Fortunately, the recently completed 79th Legislative Regular Session has changed the 30-day notification to 15 days, effective September 1, 2005.

The characteristics of the population served by the CSHSCN program contribute greatly in the significant variations in client expenditures from year to year. DSHS regularly analyzes the CSHCN Program client expenditures to operate within budget limitations. In FY 05, projected expenditures based on historical utilization data were greater than incurred costs to the state. As appropriate, funds were carried forward to FY 06 to allow additional children to be removed from the existing waiting list for the CSHCN Services Program's health care benefits. Projected costs vary due to differences in client access and utilization of third party coverage (i.e., Titles XIX, XXI, or private insurance); the wide array of possible diagnoses allowed within the eligibility criteria; and the unique medical needs of children with similar diagnoses.

Form 4 shows variations in the expenditures across MCH population types. Pregnant women, as well as infants under 1 year old, remain stable between FY 01 and FY 05. The expenditure levels

between FY 01 and FY 05 are \$ 18.1 million and \$17.8 for pregnant women, and \$188,643 and \$174,419 for infants under 1 year old. Children 1 to 22 years show a different trend. Expenditures dropped from \$25,509,699 in FY 02 to \$18,513,536 in FY 05.

Expenditures for CSHCN decreased from \$41,346,111 in FY 01 to \$29,565,393 in FY 05. This decrease can be attributed to two main reasons. First, Title V was asked by the 77th Legislative Session to transfer one-time only \$7 million in Title V funds to the Interagency Council on Early Childhood Intervention (ECI), which provides a coordinated system of services available in every Texas county for children, birth through age 3, with disabilities or delays. Secondly, the CSHCN program was mandated by the same legislative session to commit state general revenues funds of \$3 million in FY 02 and \$10 million in FY 03 as savings acquired due to CSHCN being covered by CHIP and Medicaid programs.

Form 5 indicates significant variation in expenditures by types of service. As result of the decrease in total expenditures of \$107,287,294 in FY 01 to \$83,872,474 in FY 05, every category (i.e., direct health care services, enabling services, population-based services, and infrastructure building services) experienced decreases in expenditures. The rationale behind these expenditure variations was addressed in Forms 3 & 4 budget justifications. It is also important to note that direct care services (i.e., maternity, family planning, genetics, child health, dental care for children, dysplasia, and specialty services for CSHCN) represent about 70% of the total expenditures. Yet, the Title V program addresses only about 30% of the Title V eligible women and children in-need for health care services. //2007//

/2008/ Forms 3, 4, and 5 show variations in expenditure amounts, which could be explained by directives from recent legislative sessions, the impact of changes in CHIP eligibility, and the re-directing of Title V funds to accommodate specific MCH population needs.

Form 3 shows a variation in expenditures between FY 03 and FY 06. The expenditure level increased from \$82,362,407 in FY 03 to \$89,004,743 in FY 06, representing about 8% variation. A portion of this increase is attributed to the ongoing commitment of state funds in excess of the required Maintenance of Effort of 40.2 million. The state's investment in maternal and child health continues even in light of reduced federal awards from \$39,496,620 in FY03 to \$37,574,044 in FY06.

The estimated carryforward amount of \$5,170,187 from FY07 to FY08 compared to the estimated \$10.5 million from FY06 to FY07 demonstrates that Title V eligible individuals and families remain in need of maternal and child health services. The difference of almost \$5 million was directed to Title V-funded contractors (health care providers) for the provision of services including: maternity, family planning, genetics, child health, dental care for children, dysplasia, and specialty services for CSHCN.

Form 4 indicates that the expenditures have increased from FY05 to FY06. While most expenditures remained stable across MCH population types, the CSHCN population shows an increase of \$5 million. This can be attributed to availability of additional state funds and removal of children from the waiting list of the CSHCN Services Program in FY06.

Form 5 indicates slight variation in expenditures by types of service. As result of the increase in total expenditures of \$82,362,407 in FY 03 to \$89,004,743 in FY 06, direct health services and enabling services collectively increased by 7%. Population-based services and infrastructure building services remained relatively stable with an increase of less than 2% during the period. It is also important to note that direct care services (i.e., maternity, family planning, genetics, child health, dental care for children, dysplasia, and specialty services for CSHCN) represent about 67% of the total expenditures.//2008//

/2009/ Forms 3, 4, and 5 show variations in expenditure amounts, which may be explained by directives from recent changes in available prenatal care benefits through CHIP; the

impact of changes in CHIP and Medicaid eligibility; and the shifting of Title V funds to accommodate specific MCH population needs.

Form 3

From FY04 to FY06, expenditures increased from \$80.2 million to \$87.5 million despite decreased federal awards for the same period. (\$37.9 million to \$35.1 million) The increase in expenditures was made possible by the use of carryforward funds during the period. The carryforward amount decreased from \$14.2 million in FY05 to \$4.3 million in FY08. The trend was expected to continue for FY09, however the impact of the implementation of both expanded CHIP perinatal benefits and the Women's Health Program in January of 2007 appears to indicate an increase in the carryforward amount in FY09. Expenditures actually decreased from \$86,076,731 to \$77,320,483 between FY07 and FY08 and the carryforward increased from \$4.3 to \$6.1 million. Based on this trend, Title V Program staff plan to identify alternatives for spending, pending outcomes of current discussions between HHSC and CMS regarding the impact of a July 2007 Medicaid rule change that would require potential changes to the state CHIP plan.

Form 4

From FY04 to FY08, expenditures for CSHCN increased from \$27 million to \$37 million. The increase in the CSHCN expenditures from 2004 through 2008 reflects additional state funds and a shortened process for legislative review of waiting list removals, which helped expedite removal of children from the waiting list of the CSHCN Services Program when funds were projected to be available.

Expenditures for children increased from \$17 million to \$21 million between FY04 and FY07. In FY08, \$14.9 million is the estimated amount of expenditures; a significant decrease due to services available to adolescents through CHIP Perinatal benefits and other changes in Medicaid and CHIP programs that went into effect in FY08. For example, the legislature expanded CHIP coverage to one year, eliminated the 90-day waiting period, allowed families to deduct child-care expenses, and expanded the asset limits for the program. Although Medicaid eligibility requirements were not changed, payment rates for dentists, physicians and specialists were increased and targeted efforts to increase access to Medicaid services were funded,

Expenditures for pregnant women decreased from an average of \$16 million annually (FY04 thru FY07), to \$8.6 million in FY08 partly due to CHIP Perinatal Program.

Form 5

Form 5 indicates a shift in types of services provided to the MCH population. From FY04-FY07, 67% of expenditures were for direct health care services. In FY08, an anticipated drop in Title V-funded direct care services due to CHIP Perinatal and the Women's Health Program, a Medicaid Waiver, would be expected. However, the methodology used to determine the distribution of expenditures over the four categories has been revised. For this submission, the Title V Program and the Budget Office worked together to develop a more accurate process to capture expenditures by types of service. New accounting systems provide greater ability to match labor account codes and definitions with appropriate types of service. In past, estimates were used based on available information at the time. For FY08, 77% of the expenditures are projected for direct care. (Without the change in methodology, there would have been a decrease in direct health care services from the 67% used for FY07.)

As a result of the change in methodology for this submission, the percentage for each type of service shifted from FY07 to FY08 as follows: enabling services from 8% to 6%; population-based services from 14% to 11%; and infrastructure building services from

11% to 6%. //2009//

B. Budget

Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort (MOE) amount of \$40,208,728. This represents more than \$10 million in excess of the state matching rate of \$3 state dollars for every \$4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement

The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Title V contracts program requires all MCH Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a quarterly basis. Title V program leadership reviews reports and provides feedback as needed.

For FY 06, Form 2 shows that \$11,272,213 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional \$11,272,213 for children with special care needs. The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at \$3,757,404, as shown in Form 2.

Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These grants include: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - Integrated Comprehensive Women's Health Services; 4) MCHB - State Early Childhood Comprehensive Systems; 5) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 6) Support State Oral Disease Prevention Program; 7) Texas Cancer Council - regional school health specialists; 8) Title X State Coordinated Family Planning Project; 9) CDC Pregnancy Risk Assessment Monitoring System; 10) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 11) Chronic Disease Prevention and Health promotion- Obesity Component; and 12) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement.

Maintenance of Effort and Continuation Funding

/2007/ Texas will continue to provide the maintenance of effort (MOE) amount of \$40,208,728. This represents more than \$18 million in excess of the state match rate of \$3 state dollars for every \$4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement

The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for

specialized services for children with special health care. To achieve the 30% -30% requirement, the Title V contracts program requires all MCH Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a monthly basis. Title V program leadership reviews reports and provides feedback as needed.

For FY 06, Form 2 shows that \$10,559,197 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional \$10,559,197 for children with special care needs. The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at \$3,519,732, as shown in Form 2.

Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These grants include: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - Integrated Comprehensive Women's Health Services; 4) MCHB - State Early Childhood Comprehensive Systems; 5) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 6) Support State Oral Disease Prevention Program; 7) Texas Cancer Council - regional school health specialists; 8) Title X State Coordinated Family Planning Project; 9) CDC Pregnancy Risk Assessment Monitoring System; 10) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 11) Chronic Disease Prevention and Health promotion- Obesity Component; and 12) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement. //2007//

Maintenance of Effort and Continuation Funding

/2008/ Texas will continue to provide the maintenance of effort (MOE) amount of \$40,208,728. This represents close to \$14 million in excess of the state match rate of \$3 state dollars for every \$4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement

The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Title V contracts program requires all MCH Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a monthly basis. Title V program leadership reviews reports and provides feedback as needed.

For FY 08, Form 2 shows that \$10,562,125 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional \$10,562,125 for children with special care needs. The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at \$3,520,708, as shown in Form 2.

Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These

grants include, but are not limited to: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - Integrated Comprehensive Women's Health Services; 4) MCHB - State Early Childhood Comprehensive Systems; 5) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 6) Support State Oral Disease Prevention Program; 7) Texas Cancer Council - regional school health specialists; 8) Title X State Coordinated Family Planning Project; 9) CDC Pregnancy Risk Assessment Monitoring System; 10) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 11) Chronic Disease Prevention and Health promotion- Obesity Component; and 12) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement. //2008//

/2009/ Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort (MOE) amount of \$40,208,728 plus an additional \$2,207,847 in state funds in excess of the MOE. This represents over \$16 million in excess of the state match rate of \$3 state dollars for every \$4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement

The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Title V contracts program requires all MCH Title V-funded contractors to provide child health services in the amount of at least 30% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a monthly basis. Title V program leadership reviews reports and provides feedback as needed.

For FY09, Form 2 shows that \$10,255,354 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional \$10,255,354 for children with special care needs. The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at \$3,418,451, as shown in Form 2.

Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These grants include, but are not limited to: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - State Early Childhood Comprehensive Systems; 4) Centers for Disease Control and Prevention (CDC) - Breast and Cervical Cancer Early Detection Program; 5) Support State Oral Disease Prevention Program; 6) Texas Cancer Council - regional school health specialists; 7) Title X State Coordinated Family Planning Project; 8) CDC Pregnancy Risk Assessment Monitoring System; 9) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 10) Chronic Disease Prevention and Health promotion- Obesity Component; 11) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement; and 12) CDC - Evidence-Based Laboratory Medicine: Quality/Performance Measure Evaluation; and 13) CDC - Texas Early Hearing & Detection & Intervention Tracking, Surveillance & Integration. //2009//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.