TEXAS DEPARTMENT OF HEALTH

PRIMARY HEALTH CARE PROGRAM

Annual Report

Fiscal Year 2002

Associateship For Family Health

ProtectTexas™
Texas Department of Health

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EXECUTIVE SUMMARY

The Primary Health Care (PHC) program, based in the Associateship of Family Health at the Texas Department of Health, began in 1987. The Primary Health Care Services Act, H.B. 1844, which grew out of the indigent health care legislative package enacted by the 69th Texas Legislature in 1985, created the program.

The PHC program provides prevention-oriented, education-based primary health care to Texas residents who could otherwise not receive such care. Eligibility is limited to those Texas residents whose gross family income is at or below 150% of the Federal Poverty Income Guidelines (FPIG) and who do not qualify for any other programs or benefits that provide the same services.

In FY 2002, the PHC program distributed $14,102,968 in state-allocated funds to 56 contractors across the state. Every public health region had from three to 11 contractors. Services were provided in 117 counties and 85,999 unduplicated clients received primary health care services ranging from attending a class about reducing cholesterol, to visiting a health care provider for an acute infection or a chronic condition. Costs for medical services totaled $12,395,768 for 712,764 medical services. Non-medical services cost $1,983,037 to provide 247,868 services. An additional $1,397,695 was expended for administrative costs. The total expended amount of $15,776,500 on primary care services in FY 2002 demonstrates that state-allocated funds ($14,102,968) were supplemented by local funding of approximately $1,673,532. The average cost per PHC client in state-allocated funds in FY 2002 was $163.99.

PHC contractors may include local health departments, community action programs, community health centers, private non-profit organizations, hospitals or hospital districts, government entities and university residency training programs. They provide services in a variety of ways, such as directly through a clinic, through a network of providers, or through on-site/network combinations.

Meeting the needs of the target population within the limitations of the available funding has always been and will continue to be a challenge for the PHC contractors. Each year more needy individuals are identified and enrolled for primary health care services in a facility that can provide a medical home without complete reliance on local emergency rooms for routine care. While the future may hold opportunities for new assistance avenues for portions of the medically needy population, further economic downturns have impacted the demand for publicly funded medical assistance for an increased portion of the population. Increases in numbers of additional persons seeking assistance, increased costs of medical services such as pharmaceuticals and diagnostic testing, and staffing recruitment and training costs will continue to drive communities to use available resources most effectively to meet their unmet needs and support the safety net of health care within their communities.

PRIMARY HEALTH CARE OVERVIEW

Primary Health Care Program History

In the early 1980s, economic recession and cost containment measures on the part of employers and government agencies led to a decrease in the availability and accessibility of health services for many Texans. A gubernatorial and legislative task force identified the provision of primary health care to the medically indigent as a major priority. The task force recommended that:

- A range of primary health care services should be made available to the medically indigent in Texas.

- TDH should provide or contract to provide primary health care services to the medically indigent. These services should complement existing services and/or should be provided where there is a scarcity of services.

- Health education should be an integral component of all primary care services delivered to the medically indigent population. Preventative services should be marketed and made accessible to reduce the utilization of more expensive emergency room services.

These recommendations became the basis of the indigent health care legislative package enacted by the 69th Texas Legislature in 1985. The Primary Health Care Services Act, H.B. 1844 was a part of this legislation and is the statutory authority for the Primary Health Care program administered by TDH. The act delineates the specific target population, eligibility, reporting and coordination elements required for the PHC Program. Authorization from the Primary Health Care Services Act, H.B. 1844 was given to the Board of Health to provide for the delivery of primary health care services to eligible individuals by the Texas Administrative Code, Title 25 Health Services.

Support for the Primary Health Care Services Act is broad-based and includes local government associations, organizations of health professionals, religious organizations, citizen coalitions, and consumers. It is recognized that primary health care is of major importance in reducing the burden of unnecessary illness and premature death, as well as reducing overall health care expenditures incurred by expensive crisis-oriented care.

Primary Care Services Description

In the RFP, contractors are required to provide or ensure the provision of at least the six priority services of 15 primary care services defined in the legislation. The six priority services are:

- Diagnosis and Treatment
- Emergency Services
- Family Planning
- Preventative Services and Immunizations
- Health Education
- Laboratory and X-ray

The remaining nine services that may also be provided are:

- Nutrition Services
- Health Screening
- Home Health Care
- Dental Care
- Transportation
- Prescription Drugs & Devices, and Durable Supplies
- Environmental Health
- Podiatry Services
- Social Services

Service Delivery Strategies

Over the years, contractors have provided services to clients using a variety of service delivery strategies. They are encouraged to choose the methodology that is most appropriate for their communities based upon a local community assessment and available resources. Services may be provided as direct care or through a network of providers. Some possible service delivery strategies include:

Onsite — Clinic-based health services.

Network — Health services provided through a contractual arrangement with local providers.

On-site/Network — Health services provided both in local clinics and through a contractual arrangement with local providers.

Community Participation Features

The PHC Program requires a community assessment and a Community Advisory Committee (CAC). These requirements were established at the inception of the program by the enabling legislation and have remained important tools to be utilized to guide each community's program development and implementation.

Communities must use a community assessment to evaluate, plan and implement pertinent services to the target population to meet the community's health care needs. Contractors are encouraged to seek technical assistance from the PHC Program staff or other sources regarding community assessment methodology, as well as to work with other entities within their communities. This comprehensive approach provides an opportunity for the community to develop integrated planning processes and to avoid both duplication and gaps in services.

The Community Advisory Committee (CAC) should be representative of the community, and should reflect the cultural, racial/ethnic, gender, economic and linguistic diversities found within each community. The CAC membership should include PHC clients as well as other community members selected for their areas of expertise. PHC staff may serve as ex officio members and support staff to the committee, but may not serve in an official capacity. The CAC works with the contractor to identify and prioritize the specific health care needs of the population, assist with conducting a needs and capacities assessment, identify gaps in service, and identify or design specific interventions to address these issues.

PRIMARY HEALTH CARE CONTRACTORS

Services

PHC contractors provide services based on each community's assessment and prioritization of its needs as well as an assessment of its resources that can be used to help meet those needs. Often, a community's existing health care delivery system includes resources that can be augmented and/or networked in order to expand that system and, in turn, serve more of the target population.

The number of PHC-eligible clients includes those clients who met the screening and eligibility requirements for PHC income, residency, and insurance. In addition, potentially eligible clients who present themselves to a contractor and are in immediate need of medical services, but who have not fully completed the eligibility process, or who are awaiting an eligibility determination from another program, may be seen on a one-time basis (OTB). Clients seen on an OTB status are not included in the enrollment figures.

In addition to these eligible and OTB clients, PHC contractors impact the lives of many other Texans by providing a variety of population-based services, including the screening and eligibility process, and health education and outreach services.

Current Year Operations

In FY 2002, 56 PHC contractors provided services to 85,999 individuals in a 117 county service area (See Table 1). Approximately 65% of the 117 counties served by the PHC Program in FY 2002 are designated as rural and the rest are designated as urban.[1]

Funding remained level from FY 1994 to FY 2002, when additional funds were authorized by the Legislature to address the Special Initiative Projects in Smith County and fund the Parkland Senior Care Grant in Dallas County. In FY 2002, contractors were funded through a competitive Request for Proposal (RFP) process, allowing current contractors and other interested parties to submit proposals to be considered for funding awards. Four contractors new to PHC were added; two previous contractors dropped out of PHC participation; and two contractors consolidated their agencies into one entity, increasing the total number of contractors from 54 to 56.

[1] "Urban" refers to counties recognized by the U.S. Office of Management and Budget (OMB) as metropolitan areas. A metropolitan area, as defined by OMB in 1990, is an area that must include at least one city with 50,000 or more inhabitants, or a U.S. Census Bureau-defined urbanized area (of at least 50,000 inhabitants) and a total metropolitan population of at least 100,000.

Table 1
Primary Health Care Contractors by TDH Regions
FY 2002

Region*	PHC Contractors+	Dollar Amount	Number Served	Counties Served
1	4	$1,096,449	6,225	10
2/3	11	$2,311,111	15,042	24
4/5	11	$2,354,091	14,162	29
6/5	3	$1,056,533	4,963	5
7	5	$1,311,222	5,594	11
8	7	$1,331,732	15,443	12
9/10	10	$2,870,643	14,959	20
11	5	$1,771,187	9,611	6
Total	**56**	**$14,102,968**	**85,999**	**117**

*Map of the TDH Public Health Regions is included in the appendix

+PHC Contractors by description and location are included in the appendix

PHC contractors are local health departments, hospitals or hospital districts, community health centers, community action agencies and other private, non-profit health and human service providers (See Table 2).

Table 2
Contractors by Organization Type
FY 2002

Organization Types Providing PHC	**Number of Contractors**
City and/or County Health Departments	11
Community Action Programs	3
Community Health Centers	19
Hospitals or Hospital Districts	11
Public Health Region (Administrative Unit of TDH)	2
Private Nonprofit Organizations	9
University Residency Program	1
Total	**56**

FY 2002 Annual Program Reports submitted by each contractor yielded information on the numbers of persons served by the program. In addition to the 85,999 unduplicated eligible clients provided with PHC medical and non-medical services, the contractors also provided screening and eligibility services and provided referrals to other programs for 105,167 persons, immediate medical services to 5,605 OTB clients.

Medical Services

Contractors reported their operating costs to the program by medical service type and represented the number of services delivered to the PHC clients (Table 3). The contractors reported total expenditures for services of $14,378,804 for medical and non-medical services. This information is summarized to reflect the average costs of services provided to PHC clients, although this representation is a composite of averages and does not reflect an accurate cost of providing a specific service or service type.

A total of 712,764 medical services were provided. The most frequent service includes preventive and primary care through the provision of client education/counseling, prenatal (pregnancy) care, well-child exams, immunizations, gynecological exams with/without contraceptive management, and adult baseline or periodic physical exams.

PHC contractors also provided 247,868 non-medical services to both PHC clients as well as non-eligible clients in FY 2002 (Table 4). Some non-medical services, such as health fairs and health education classes, are not limited to PHC eligible clients but are made available to the entire community due to the setting in which they are provided and their general appropriateness for everyone.

Non-medical services are defined on PHC Quarterly and Annual Reports as the following:

- Screening and eligibility
- Transportation
- Other non-medical services, including case management

Table 3

Breakdown of Medical Services Provided and Costs Charged to the PHC Grant in FY 2002

Medical Service Type	Total PHC Dollars Spent	Total Number of Medical Services Provided	Average Cost Per Service to PHC
Diagnosis & Treatment	$5,088,487	241,257	$21.09
Emergency Services	$50,746	566	$89.66
Family Planning	$86,306	3,187	$27.08
Preventive Health	$954,170	61,028	$15.64
Health Education # of one-to-one sessions # of group sessions	 $602,790 $361,265	 44,514 14,065	 $13.54 $25.69
X-rays	$449,129	7,757	$57.90
Pharmacy	$2,604,634	148,467	$17.54
Laboratory	$1,440,344	143,376	$10.05
Other Diagnostic Tests	$102,300	2,630	$38.90
Dental Services	$162,939	7,465	$21.83
Medical Referrals	$366,011	24,495	$14.94
Other Medical Services	$126,647	13,957	$9.07
Grand Total	$12,395,768	712,764	

Table 4

Breakdown of Non-Medical Services Provided and Costs Charged to the PHC Grant in FY 2002

Service Type	Total PHC Dollars Spent	Total Number of Non-Medical Services Provided	Average Cost per Service
Screening and Eligibility	$1,511,406	164,551	$9.19
Transportation	$62,958	4,469	$14.09
Other Non-medical Services	$408,673	78,848	$5.18
Grand Total	$1,983,037	247,868	

The contractors reported total expenditures of $14,378,805, for the medical and non-medical services detailed in Tables 3 & 4, and an additional $1,397,695 expended for administrative costs. This represents a reported total PHC program cost of $15,776,500 inclusive of TDH and non-TDH funding. PHC award dollars do not cover all expenses associated with providing care to this population, and were supplemented by at least $1,673,532 in local funding.

Clinical Services and Quality Measurement

PHC contractors provide preventive and primary health care services to communities based on the needs and resources identified by communities. Analysis of this information impacts program goals and program development by indicating when, what, how much, where, and for whom services are most needed.

The success of health care programs in facilitating improved health status can be assessed through process evaluation, impact evaluation, and, if enough time has elapsed to see a significant change, outcome evaluation.

A **process objective** indicates the number of people from the target population who participate in the contractor's services. This measures the community's response to the contractor's services and is an effective tool for on-going program evaluation and development.

Impact objectives show short-term changes in targeted behaviors and levels of awareness within the target population that have occurred because of the contractor's services.

Outcome objectives indicate long-term benefits in general health status within the target population that result from maintaining short-term improvements over five to ten years.

Process evaluation assesses aspects of program development and implementation (e.g., materials, implementation activities, levels of participation) as well as participants' and stakeholders' reactions to the program. Process objectives are stated in terms of numbers of individuals in the target population who take advantage of specific services.

All PHC contractors used the target number of unduplicated individuals to be served during FY 2002 as their primary process objective. According to data submitted on the "Performance Indicators Report Summary" for FY 2002, 27% of the contractors met or exceeded the number of unduplicated individuals they targeted to serve in their RFP response. An additional 23% achieved 80% of their estimated number to be served. Technical assistance was provided to contractors who did not meet their target number in order to help them increase the number served in subsequent reporting periods.

Impact Objectives Based On Outcome Objectives

Impact evaluation assesses the short-term effects programs have on specific behaviors in the target population. Behaviors that individuals control in varying degrees in order to take an active part in becoming healthier include, but are not limited to: nutrition,

exercise, tobacco use, alcohol consumption, sexual activity, and increased knowledge and skill in other areas of self-care.

PHC contractors chose impact objectives for their programs based on community assessments of their target populations that identified diabetes and cardiovascular disease as areas of most importance.

- 65% of the PHC contractors identified diabetes
- 30% of the PHC contractors identified cardiovascular disease

Impact objectives that support decreasing the mortality and morbidity of complications from diabetes include:

- sustained blood glucose control
- weight control
- exercise
- diet and nutrition
- increase knowledge related to self-care through education and counseling

Impact objectives that support decreasing the mortality and morbidity of cardiovascular disease include:

- sustained blood pressure control
- weight control
- decrease cholesterol
- decrease blood lipids (fats)
- weight control
- exercise
- diet and nutrition
- increase knowledge related to self-care through education and counseling

Fifty-three percent (53%) of the PHC contractors met or exceeded their impact objectives as demonstrated by meeting the target percentages of their client populations who successfully changed their behaviors, e.g., sustained weight loss and blood sugar control.

Ninety-two percent (92%) of the impact objectives met were related to diabetes management. The other eight percent were related to the management of cardiovascular disease. This reflects the fact that diabetes outnumbers cardiovascular disease in the times it is mentioned in community assessments as a major concern in the population assessed.

Outcome Evaluation

Outcome evaluation assesses achievement of ultimate program goals. This is done by examining changes in health status and quality of life for defined populations as evidenced by certain indicators. Such indicators might include changes in morbidity, mortality, disability, or risk factors.

Through community assessments and surveying recent morbidity and mortality data, PHC contractors identified two outcome indicators:

- decrease the mortality and morbidity from complications of diabetes
- decrease the mortality and morbidity from cardiovascular disease

Outcome objectives are measured from five to 10 years after the start of a program. Information gathered from monitoring process and impact objectives on a regular basis at short intervals will indicate if and what "fine tuning" should be done to attain the long-range objectives that result in general improved health status for the community.

Interventions for PHC Clients in FY2002

According to self-reported data from PHC contractors, the most frequently cited health indicators for accessing PHC funded services are diabetes, hypertension, cardiovascular disease, high cholesterol and/or high lipids (fats) in the blood. These factors are the same indicators as reported in previous years.

CONTRACTOR ACCOMPLISHMENTS

Many areas of Texas have limited medical and social services resources available, which often results in a local Primary Health Care (PHC) contractor being the single provider of health care services to this population within a community and/or its surrounding areas. These agencies are pivotal in the identification, treatment and referral of indigent and working poor clients' health issues and the impact of their health care on the medical resources of the local community. PHC contractors and clients were challenged by continued limitations of level funding from FY 2001, and health industry issues regarding recruitment, training and retention of qualified healthcare providers in a competitive market. PHC contractors developed strategies utilizing PHC funding to cope with the unmet needs of their communities, but consistently reported continued and growing demands for more services for the populations served. The following materials are excerpts from contractor Annual Reports to the Texas Department of Health expressing their achievements, limitations and proposed future directions for their communities.

Community Health Center of Lubbock, Inc. (PHR 1) located in urban Lubbock and serving the surrounding rural areas, provides primary and preventive health care as well as dental, podiatry and optometry services. The agency has used PHC funding to increase access to health care services for uninsured adults impacted by diabetes, hypertension and lipid disorders after the community needs assessment identified dental care, annual health exams and diabetic care services as needed services in the community. Most primary care and some specialty care is offered on site, but the agency still faces the task to get clients into specialty care services such as radiology, neurology and cardiology when they are not available on site.

Andrews County Health Department (PHR 9) of Andrews County provides comprehensive primary health care and public health services for its community. They have used PHC funds to expand linkages and cooperative efforts between existing Health and Human Services providers and enhanced the providers' ability to meet the locally determined needs. They have been successful in increasing the numbers of clients utilizing the indigent drug programs; improving flow in the family planning/gyn/PPIP (Put Prevention in Place) clinic and obtaining funding from other programs to meet some additional service needs of PHC clients. The agency continues to face challenges in funding dental care for adults; maintaining preventive controls in the hypertensive and diabetic populations, and continued education to the client population regarding medications and child health needs. They may anticipate seeing added clients as the local hospital district has implemented policy changes related to unfounded services to undocumented persons.

Midland County Hospital District (PHR 9) in Midland operates Community Health Care Centers (CHCC) with various local health and human services agencies and local physicians to address planning and providing care for uninsured and underinsured patients. PHC funding for staff increased opportunities for patient advocacy and more complete coordination of local resources to reduce duplication of services. CHCC successfully provided the Indigent Prescription Program delivering over $350,000 in free

prescriptions to PHC patients and other Midland residents. They continue to provide an outreach worker to make home visits to homebound patients to assist them with the application process for this program. Limitations in available provider appointment slots, primary care treatment needs for persons with Hepatitis C, and clients needing surgical care continue to be challenges for the CHCC.

Centro San Vicente (PHR 10) of El Paso leverages PHC funds with local and other federal funds to maintain a collaborative effort of over 30 assistance programs known at the Community Voices of El Paso. They strive to maintain access to basic primary care services for the indigent and medically underserved residents of El Paso, where 30% of the population is uninsured. In FY2002, they implemented Puente de Salud, a health education and lifestyle promotion program that promotes health-enhancing behaviors through education and skills development interventions in areas of diabetes, nutrition and tobacco. Future plans include a proposed service expansion into oral health and stronger linkages with podiatry, ophthalmology and child obesity education programs.

North Central Texas Community Healthcare Center, Inc. (PHR 2) now serves clients in 14 counties, including the Wichita Falls urban area. The center received increased funding in FY2002 to serve more clients and have expanded their network of specialty providers to include referrals to women's health, gastroenterology, oncology and cardiology services. This community has had unmet needs in both the adult and child populations, which has led them to see many clients with multiple chronic illnesses that require extensive work-ups to stabilize them. However, those clients are now receiving appropriate care and have a health home to turn to when illness strikes. The agency has available capacity to absorb additional clients through their outreach and health awareness programs.

Community Health Services Agency, Inc. (PHR 3) in Greenville serves the residents of Hunt and Fannin counties in North Central Texas. Their community population is highly rural and primarily presents with chronic disease conditions of diabetes, hypertension and high cholesterol often requiring primary services, medication, dental health and mental health services provided by PHC funds. The agency has also used PHC funds to educate clients regarding their own disease process and has established programs to include patients as partners through monitored self-management goals. PHC-funded services are the only medical care services provided on a low-income basis within this community and without PHC funding, many of these clients' needs would go without access to care.

Titus County Memorial Hospital District (PHR 4) in Winfield, serving the Titus and four surrounding rural counties, operates the Northeast Texas Rural Health Clinic (NTRHC) and has provided a medical home to uninsured and underinsured patients. This medical home concept offers these patients an alternative to the emergency room and an opportunity to prevent and manage chronic health care problems. The program continues to play an essential role in providing prevention services, education and direct care services to families and individuals who otherwise would lack access. The PHC program continues to provide home glucose monitors and strips to PHC clients as an incentive to attend diabetic education classes. Together with medication assistance from

another provider program, the NTRHC has seen greater incidence of sustained blood sugar control among clients, although the manpower required to support this activity remains a challenge.

Memorial Medical Center – San Augustine (PHR 5) of San Augustine County and serving the surrounding counties of East Texas, has seen an increase in the number of clients enrolled in FY2002 and projects more clients will become eligible as the area continues to suffer the economic pressures of unemployment and loss of employer sponsored insurance programs. They have realized an increased awareness in preventive care with their clients, and provide individual education during clinic visits, outreach education activities, diabetes support group meetings, and participate in community and employer sponsored health fairs. This Rural Health Clinic operation projects that it would cease operations and revert to a private physician practice without the current funding provided the PHC program.

San Jacinto Methodist Hospital Family Practice Residency Program (PHR 6/5S) located in Baytown near the Houston area is a part of the San Jacinto Methodist Hospital. This program trains family practice physicians who will serve in the rural areas of Texas through clinical operations in Chambers and Liberty counties, serving those counties and portions of east Harris County. Physician training in these settings is intended to sensitize the providers to the needs of the clients in poorer communities of Texas. The program has added patient education services through on-line services, increased teaching classes for diabetes patients, increased numbers of clients receiving dental services, and improved access to medications through community pharmacist outlets with PHC funds in FY2002. This agency plans to expand services in the future into other areas of the current counties served.

Fort Bend Family Health Center (PHR 6) of Richmond, located in Fort Bend County near the Houston metropolitan area, is a federally qualified health center look-alike developed through coordination of various public and private agencies and funding resources. This health center is the sole source of low-cost health care for the medically underserved population in Fort Bend and Waller counties. The project focuses on the disparities of diabetes and cardiovascular diseases in an uninsured minority population. PHC enables this agency to operate the clinics and provide services that otherwise would be unavailable to approximately five percent of the population of these two counties.

Barrio Comprehensive Family Health Care Center, Inc., (PHR 8) providing services in the east and west quadrants of San Antonio to serve Bexar County residents, focuses their PHC efforts on health and nutrition education for the management of complications of diabetes, hyperlipidemia, weight management and blood pressure. This agency sees a population frequently diagnosed with Type II Diabetes and increased incidences of Acanthosis Nigricans in the San Antonio area. This agency strives to ensure their PHC clients complete a multiple session education program and counseling to stress preventive management of their disease conditions.

Community Health Development, Inc., (PHR 8) located in Uvalde and serving the residents of both Uvalde and Zavala counties, has increased the capacity of the community to provide access to preventive care services to the uninsured. The PHC program also has allowed them to focus on providing the identified care needs from chronic illnesses of diabetes, hypertension, cardiovascular disease and cancer through comprehensive disease management efforts to prevent complications of these diseases. The agency proposes to expand its operating hours to add more evening and weekend hours to further accommodate access for the working poor families in FY2003.

Llano County Hospital Authority (PHR 7), located in the Hill Country area, serves clients in four clinics located in San Saba, Llano and Burnet counties since expanding their services in FY2002 into the Marble Falls, Kingsland and Llano communities. Over one-third of the clients screened were eventually enrolled into their PHC program. Staff funded by the PHC project work with the clients to coordinate the available community resources, such as Medicare clients without prescription coverage, PHC client who exceeded the two prescription limit, and uninsured local community residents, to obtain medications through a pharmaceutical company assistance program. The most challenging aspect of their operations continued to be the growing need for increased prescription services as many of their clients must choose between prescribed medications or other personal financial obligations.

United Medical Centers (PHR 8) of Eagle Pass serves persons in Maverick and Val Verde counties on the Texas-Mexico border. This area is particularly challenged with the lack of access to primary health care services for residents living in outlying colonias in rural Maverick County. The residents of this area continue to be medically underserved due to special needs and circumstances, while they continue to suffer disproportionately with chronic, communicable and infectious diseases. The service area experiences significant health manpower shortages in all health-related areas and most clients are characterized by both extreme poverty and a lack of insurance. They utilize PHC funding for health care services to cover staffing costs for the evening clinic hours to enhance continuity of care for patients. This agency sponsors a Recruitment and Retention Program featuring a rural clinical rotation opportunity for health professions. While the Center has sought and obtained funding for various specific needs, they continue to be reliant on the PHC program funding for their general support and have not established any definite alternative funding mechanisms.

City of Laredo Health Department (PHR11) provides services at the La Familia Health Care Center to eligible clients in the Webb County area. This community along the Texas-Mexico border faces twice the percentage (31.2%) of persons earning annual incomes below the federal poverty level compared to the statewide total (15.4%). The community incidence of high mortality from cardiovascular disease, cancer, stroke and complications from diabetes have prompted the agency to focus on lifestyle modification, health risk assessments and health education using bilingual health educators and promotoras to serve the predominantly (94.3%) Hispanic population of that community.

PHC continues to fund many of the laboratory diagnostic testing services required, and provides assistance with medications to a portion of the population. But the area continues to see to unmet needs in adult dental care services, assistance to purchase eyeglasses and additional diagnostic examinations.

Community Action Corporation of South Texas (PHR11) serving Brooks, Jim Wells and San Patricio counties in the Coastal Bend area, but also providing services to clients from the surrounding rural counties. The local Community Health Advisory Committee completed a community needs assessment this year and has prioritized health issues of prescription costs, hypertension, diabetes, high cholesterol and health care costs for the area. Their recommendations to the agency's Board of Directors were to continue to provide patient education and care to clients with diabetes and hypertension and to seek funding to start a Medicine Assistance Program. The agency is a community-based organization providing the outreach and intake services for the CHIP Program, and has expanded their program service base through breast and cervical cancer screening services, housing assistance services, and child development instruction. However, the agency continues to struggle with changing funding limitations.

SPECIAL PROJECTS OVERVIEW

St. Paul Healthcare Outreach Initiative

Background
The St. Paul Children's Foundation subcontracts with Smith County Health Department to provide services to improve health care and the coordination of social services within the underserved communities in Smith, Morris, Van Zandt, Rains, Henderson and Cherokee counties. These two organizations have a long-standing partnership on resolving issues related to children and the health status of uninsured children of this extended area. The most significant issue before this project was the development of a children's medical and dental clinic to serve uninsured children of the area, which was addressed through fundraising efforts to establish an operational clinic. It is a partnership that has had a significant impact on the community with its full-time clinical staff and bilingual support staff.

In August 1999, a group of Texas-elected officials including Senator David Cain, Senator Bill Ratliff, and Representative Bob Glaze toured the St. Paul Children's Clinic while meeting with St. Paul Foundation board members and supporters. The group was impressed by the community project involving the St. Paul Foundation, area hospitals, businesses, and public health. Senator Cain's office requested a budget for the proposed mobile unit that had not been funded and offered it into the State budget as proposed in the original funding request. Beginning in FY 2000 the project was approved and a two-year contract was issued to purchase the mobile van and equipment required, recruit and train staff, determine roles and responsibilities, and provide services in rural areas. The initiative has continued to receive funding through the Texas Department of Health for the FY 2002 and FY 2003, with funds appropriated during the 77th legislative session.

Operations
Counties were selected for the program (Smith, Cherokee, Morris, Rains, Henderson and Van Zandt) by reviewing health status indicators and availability of resources. These counties were intended as a starting point to address need. Initial service needs were primary care, immunizations, health education/fairs, and screenings. It was intended that each community would eventually participate in the development of services to be offered to meet its unique needs. The project also has provided health education rotation opportunities for nursing and medical students from UT Health Center at Tyler.

The St. Paul mobile unit was designed as a transport vehicle to move supplies, equipment and staff to an outlying clinic site. Minimal fixed equipment such as examination tables and scales, were purchased for each site. A local community coordinator would ensure the site was ready for a scheduled clinic operation, and that appropriate patients had booked appointments. The mobile unit has assisted in the establishment of a primary care clinic in adjoining Marion County and continues to assist the Longview community in establishing a similar program in Gregg County.

The negotiated scope of work for this project during FY2002 specified the provision of:

- a minimum of one health fair per county per year,
- a minimum of one health screening per county per year,
- a minimum of one pediatric and one adult immunization clinic per county per year as desired by the local community,
- educational sessions to community groups on preventive health care issues important to the community,
- primary care to individuals and families residing in the counties to a total of 600 clients for the primary health care program.

During the FY 2002 operating year, eleven health fairs/screenings were held covering the required counties with the exception of Rains County. Technical assistance will be provided to correct this occurrence in the next year. Ten pediatric and nine adult immunizations clinics were held at the request of the local communities, resulting in 748 pediatric and 300 adult immunizations. Three educational sessions were given to school-age children, with 508 children attending the sessions. Primary care was provided to 724 unduplicated individuals. Ninety-five referrals to specialists and 32 referrals to emergency rooms were made.

Parkland Senior Care Grant

The Parkland Foundation, an agent for the Parkland Memorial Hospital, located in Dallas, (PHR 3) received a funding award in FY 2002 of $193,017 to provide start-up costs to establish a pilot project to provide case management and transportation services to senior citizens in Dallas County. The project was designed to provide services to senior citizens age 65 years or older residing in Dallas County to improve and maintain health, quality of life and independence through timely access and delivery of health care and the coordination of health and social services.

The project included the provision of case management services to Parkland Hospital patients, beginning mid-2002. A focus group was utilized to represent the multi-ethnic population of the area and the agency conducted an asset-mapping exercise to best determine the location, accessibility and types of services available. These tools were used to evaluate and plan for providing the needs of the targeted population and can be revised and utilized to serve the project in future periods.

A nine-month contract was awarded for December 2001 through August 2002. Contract documents were approved and operational tasks began February 2002. The focus group tasks, pre/post test tool development, and purchase of the mobile van were completed in July 2002. Case management services were projected to begin in June 2002 with a goal to provide services to 175 unduplicated clients in Low Intensity Case Management and 75 unduplicated clients in High Intensity Case Management individuals in FY 2003.

By the end of the FY 2002 contract period, this project had enrolled 27 in Low Intensity Case Management Services; 14 clients High Intensity Case Management; had provided health screenings to 35 seniors; and had provided transportation services to 129 seniors. Outreach activities were initiated with local service entities involved in senior citizen care and interests and 14 outreach events and 13 educational programs were held to acquaint the community with the project.

PRIMARY HEALTH CARE POPULATION SERVED

Primary Health Care (PHC) clients represent all races, ethnicities, genders and age groups. The PHC program provides benefits to people in Texas who have a family income at or below 150% of the Federal Poverty Income Guidelines. PHC clients live in every region of the state. While some are employed, some are not and most of them did not receive regular medical care before qualifying for the PHC program. Prior to receiving PHC services, many of clients received their only medical care from hospital emergency rooms.

Annually, the PHC program estimates its target population by taking the number of Texans who have incomes estimated at or below 150% of the Federal Poverty Income Guidelines, and subtracting those Texans within that income category who are estimated to have employer group insurance, private insurance, Medicaid, Medicare or are served by the County Indigent Health Care Program (CIHCP). The remaining individuals, often called "the working poor," are considered the target population for the PHC program.

As Table 5 shows, the number of individuals potentially eligible to receive PHC services in FY2002 was estimated at 1,236,914. This reflects a decrease compared to FY2001 in the numbers of persons estimated eligible for PHC by approximately 817,000. This finding may be due to an increase in the percentage of persons covered by employer or private insurance (17%) [2] as well as the percentage of persons covered by Medicaid (13%)[3].

In FY2002, PHC contractors reported serving 85,999 clients, or 7% of the estimated target population. In comparing the percentage of persons served in FY2002 (7%) to FY2001 (4.15%) and FY2000 (4.5%), contractors provided services to more of the estimated eligible population.

Table 5

Target Population of the PHC Program

FY 2002

Estimated number of persons in Texas at or below 150% of poverty[1]	6,066,220
Estimated number of Texans below 150% of poverty with employer group insurance or other private insurance, excluding Medicaid and Medicare[2]	2,020,051
Average monthly enrollment in Medicaid (all programs)[3]	2,018,681
Estimated number of Texans below 150% of poverty with only Medicare coverage[4]	765,796
Estimated number of individuals in FY 02 enrolled in the County Indigent Health Care Program (CIHCP)[5]	24,778
Estimated target population of the Primary Health Care Program	1,236,914

[1]Texas Department of Health, Bureau of Vital Statistics, Texas A&M University, Texas State Data Center, 2002 Population Estimates, May 2002.
U.S. Bureau of the Census, 1990 Census of Population and Housing, Summary Tape File 4A, (Table) "Age by Ratio of Income in 1989 to Poverty Level."
[2]U. S. Bureau of the Census, Current Population Reports, Health Insurance Coverage: 2001, September 2002.
[3]Texas Department of Human Services, Monthly Medicaid Eligibles File Extract, FY2002. Texas Health and Human Services Commission, Research and Forecasting Department Division of Research, Planning and Evaluation.
[4]U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Enrollment Reports for 2001.
[5]Texas Department of Health, County Indigent Health Care Program, FY 2002.

Demographic Information

Program enrollment begins with the application process for the entire household or a family unit within a household. Often, the application includes additional persons within the household who will be determined eligible for PHC services, but who will never present for a medical service from the contractor. Program reporting requirements are defined to include the enrollment process as a funded PHC service, although it is acknowledged that some portion of the enrolled clients will not choose to access services during the period of enrollment. Since demographic information is generally collected at the time medical services are provided, those clients who do not receive a medical service will not be reflected in the various categories of demographic information and description. That portion of the population counted for enrollment only is defined where possible within each category.

Service Delivery Integration (SDI) is a TDH initiative to improve direct health care service delivery of contractors by streamlining administrative policies and procedures through the integration of policies and the development of an automated business system that determines eligibility, uses single client data entry and real time billing and reporting with weekly reimbursement. Due to the integrative nature and design of the SDI Project, clients are considered enrolled all participating programs, although many will receive their services funded through sources other than PHC, since PHC is the payor of last resort. SDI enrollment figures will include all clients enrolled in the SDI Project, not just the program entity providing funding for medical services.

Contractors other than SDI also reported numbers of clients served above the number of clients who received a medical service during the contract year. The numbers of clients reported as served, but not receiving a medical service are included with the SDI figures above to comprise the Enrollment Only category in each chart. Additionally, there were a nominal number of clients reported as served (1.4%) that did not include the full extent of data as requested. Overall, approximately 81% of the enrolled clients served receive a medical service and demographic information is collected at that time. Information regarding the poverty status, age, gender and race, as well as educational, employment or marital status for persons age 18 or more may not reflect exact figures due to manual calculations and electronic conversions of information.

Poverty Level of PHC Clients Served in FY 2002

The majority (54.3%) of PHC clients served in FY 2002 live at or below 100% of the federal poverty income limits (Table 6). No estimate of poverty status is provided for the numbers of enrolled clients (85,999) who did not access a medical service (15,225 or 17.7% of total clients served as reported in Table 4 on page 6) in FY 2002. A nominal portion (1.4%) of clients was also excluded in the percentage breakdown of poverty level due to data management issues in compiling information manually or electronically.

Table 6
Poverty Level of PHC Clients Served
FY 2002

Percent of poverty	Number of Clients Served	Percentage
150% - 126%	11,369	13.2
125% - 101%	11,587	13.5
100% - 76%	22,169	25.8
75% - 51%	10,920	12.7
50% - 26%	6,454	7.5
25% - 0%	7,113	8.3
Missing Data*	16,387	19.1
Total	**85,999**	**100.0**

* Data collected by each contractor may not be reflected in consistent terms or may not show every type of information for all clients served. Poverty information was not collected on a portion of the clients served (1.4%) due to limitations or restrictions on data management systems or errors in manually compiling record counts. This figure also contains that share of clients not receiving a medical or non-medical service other than enrollment processing.

Race Data

Race data are collected when medical services are provided. While all races are represented among the PHC program clients served (Table 7), the majority of clients served (57.2%) reported themselves as Hispanic. This reflects a continued decrease in the reported Hispanic share of the population served from 62% in FY 2001 and 74% reported in FY 2000. It is presumed the economic pressures of the state are encouraging additional persons within the eligible population to seek publicly assisted health care, rather than indicative of a shift in the racial demographics of the target population.

Table 7
PHC Clients Served by Race
FY 2002

Race	Number of Clients	Percentage
Hispanic	49,220	57.2
White, Non-Hispanic	13,636	15.9
African American	4,653	5.4
Asian	312	0.4
Native American	49	0.1
Not Specified	2,905	3.4
Enrollment Only*	15,224	17.7
Total	**85,999**	**100.0**

* Race data is not collected on clients served until a medical service is provided and a medical record is established.

Educational Level
Information on education level is collected only from the clients aged 18 years or older who receive a medical service (Table 8). This information is optional and in FY2002, the Program observed an increase in the numbers of clients served who were reported as the "did not specify" category for this information. This is a result of increased numbers of clients omitting this information and contractors opting not to collect, compile and report educational level information on the participating clients due to lack of data management systems to support this effort. Consequently, this category increased from 27% in FY 2001 to 35.1% in FY 2002, although it is not clear that this is representative of any change in the actual population served.

Table 8
PHC Clients Served by Education Level
FY 2002

Education Level	Percentage
Clients with less than a high school diploma	35.4
Clients with a high school diploma or equivalency	24.1
Clients had more than a high school diploma	5.4
Clients did not specify an education level	35.1
Total	**100.0**

Gender and Age
In total, the majority of PHC clients served in FY 2002 were female (Table 9), although through the younger ages, gender was distributed evenly until the ages of puberty, when the numbers of females increased proportionally. Data on education, marital, and employment status are collected only on those PHC clients age 18 or more. Slightly less than half of PHC clients aged 18 or older reported themselves as unemployed (39%), and slightly more than half reported themselves as married (52%). See Table A in the Appendix for summary highlights of PHC program data from FY 1992 –2002.

Table 9
Gender by Age of PHC Clients Served
FY 2002

Age	Percent Male	Percent Female
Less than 1 year	49.5	50.5
Ages 1-4 years	48.5	51.5
Ages 5-12 years	49.1	50.9
Ages 13-19 years	41.3	58.7
Ages 20-64 years	29.9	70.1
Ages 65 and older	36.6	63.4
Total	33.3	66.7

Client Satisfaction Surveys
In FY 2002, the PHC program used a client satisfaction survey tool developed during FY 2000 to gain information regarding the level of satisfaction clients felt concerning the quality of care they received from the providers. Depending on the client's preference, surveys are provided by the contractor in either English or Spanish. Contractors were required to collect a minimum of 10 surveys per month, and were directed to summarize the responses quarterly.

Completion of the surveys is voluntary, and it is an option for any client to participate. Results from FY 2002 do not vary significantly from the results of the same survey tool used commencing in FY 2001. Approximately 79% of clients completing the surveys are returning (rather than new) clients, and 66% have an established appointment for their visit. Of those without appointments, 72% report being able to be seen by a provider in the clinic on the same they arrived for a service. Approximately 94% either agree or strongly agree they have received high quality health care and only 27% report going to another provider or location for their health care needs.

The tabulated results from the survey are as follows:

Table 10
Client Satisfaction Survey Results
FY 2002

Survey Question	Summary Results	
Is this your first visit to the clinic?	19% yes 80% no 1% not sure	
If yes, were you seen within two weeks of your first call?	74% yes 20% no 6% not sure	
Did you have an appointment for your clinic visit today?	66% yes 33% no 1% not sure	
If you had no appointment, were you seen in the clinic the same day?	72% yes 21% no 7% not sure	
Do you pay any money for the services you get at this clinic?	60% yes 36% no 4% not sure	
Who is being seen at the clinic today?	70% myself 7% spouse 0% domestic partner 15% child (1)	3% children 2% parent(s) 1% friend 2% other
What services did this person(s) get today?	30% saw the doctor 13% saw the nurse 6% picked up medications 7% lab work or blood work 11% blood pressure check 2% cholesterol screening 6% diabetes check-up	1% cardiac care (heart) 5% routine physical 3% pre-natal services 5% intake appointment 4% immunization/flu shot 7% other
This clinic provides me with high quality health care	50% strongly agree 44% agree 4% don't agree or disagree	1% disagree 1% strongly disagree
Does this clinic meet your medical needs?	92% yes 4% no 4% not sure	
Do you go anywhere else for your health care?	27% yes 71% no 3% not sure	

THE FUTURE

Texas recognizes the increasing need for health care services for Texans without sufficient means to pay for their health care needs. Texas projects increased growth in the eligible population, which further contributes to growing demands for health care services and funding in many communities. Economic pressures of unemployment, high health care costs, rising health insurance costs and limited availability, and lack of new or increased State funding resources continue to compel local communities to provide more of the community health safety net for their neighbors. Without funding for local health care providers, demand for services may go unmet, individual needs may not be addressed timely to maintain optimum health, and more catastrophic health care costs may be realized by the community due to advanced stages of illnesses and conditions encountered. At the national level, President George W. Bush is proposing to include $114 million to double the number of FQHCs over the next five years. It is anticipated that Texas will undertake this effort at the state level.

TDH will focus on the following areas to successfully meet the demand for primary health care services for Texans.

Data Management

Managing data and reporting accurate information to the program continues to be a challenge for many of the contractors. Some contractors have purchased data management software and/or programmed reporting requirements into their internal business systems, while other contractors unable to purchase updated systems continue to track required information manually. Continued efforts to integrate program reporting needs with TDH supported information systems will improve the contractor's ability to address the information management requirements. Efforts to increase informational technology support for PHC have not been fully implemented as projected for FY 2002, although major design and implementation tasks have been completed. However, further consolidation and re-organization of health care agencies in Texas may positively impact the resolution of the systems design, development, and installations.

Self-Developed Performance Measures

For fiscal years 2003 & 2004, PHC contractors will continue developing and tracking their own performance measures under the current service scenario. Each contractor will be responsible to set outcome, impact, and process objectives to achieve the stated objectives of their own community. Contractors are expected to base the goals and objectives on the top five health indicators identified during the most recent community health assessment process. Monthly and quarterly reporting requirements and formats may be revised to reflect each contractor's progress toward their community objectives.

Competitive Grant Process

The original intent of the program was to fund the provision of health care to families without other means of accessing health care, while at the same time asking contractors to partner with other resources in their community to establish internal health care funding for families in need. Due to the amount of time required to move a community to a point that they can sustain such a resource, the PHC grants have remained with many of the same agencies for multiple years. As a result, the efforts to find replacement funding have often waned and additions of new or increased funding sources have not occurred in each community and some local organizations have become dependent upon the funding awards received from PHC to maintain their business viability within the community.

Appendix

(TABLE A) **Highlights of Primary Health Care Program Data in Fiscal Years 1992-2002**

CATEGORY	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
Total clients served	105,710	73,126	98,780	100,563	109,059	107,308	87,719	85,858	89,443	85,247	85,999
Cost per client (including all types of service)	$ 79.80	$ 114.29	$ 111.72	$ 123.62	$ 118.76	$ 128.47	$ 150.19	$ 150.33	$ 178.56	$ 194.79	$ 163.99
Cost per Diagnosis &Treatment service only	$ 22.49	$ 22.49	$ 25.07	$ 24.10	$ 24.03	$ 26.54	$ 21.80	$ 21.44	$ 22.18	$ 21.17	$ 21.09
Cost per medical service	$ 12.12	$ 11.16	$ 14.04	$ 15.08	$ 14.94	$ 17.99	$ 16.80	$ 17.98	$ 26.47	$ 18.19	$ 17.39
Total services provided	682,663	650,675	668,363	705,682	773,359	670,915	784,060	810,298	603,339	643,069	712,764
No. of clients screened and referred to all programs	76,239	121,718	162,629	173,347	158,197	161,580	157,026	165,799	156,581	131,564	105,167
No. referred to Medicaid	16,911	17,646	23,616	42,048	60,093	64,568	67,574	68,078	63,123	60,288	*
No. referred to CIHCP	12,996	20,769	23,080	17,386	16,116	16,553	19,401	13,204	12,584	13,817	*
Clients at or below 100% FPIL	64%	76%	79%	77%	75%	72%	70%	73%	67%	56%	54%
Unemployed Clients (age adjusted)	67%	61%	61%	57%	54%	51%	45%	47%	48%	51%	39%
Clients Served: Less than 1 year	w	w	w	1%	1%	1%	1%	1%	1%	2%	1%
Age 1 – 4	w	w	w	3%	4%	5%	5%	5%	4%	4%	3%
Age 5 – 12	w	w	w	11%	12%	11%	12%	11%	10%	9%	7%
Age 13 – 19	w	w	w	28%	28%	18%	18%	12%	12%	9%	7%
Age 20 – 64	w	w	w	51%	50%	59%	58%	65%	66%	69%	73%
Age 65 and older	w	w	w	6%	5%	6%	6%	6%	7%	7%	8%
Ethnicity: Hispanic	53%	58%	58%	60%	64%	70%	67%	74%	74%	62%	57%
White, not-Hispanic	25%	21%	23%	21%	19%	18%	19%	17%	17%	15%	16%
African American	17%	19%	17%	16%	15%	10%	11%	7%	8%	6%	5%
All other/Missing Data	5%	2%	2%	3%	2%	2%	3%	1%	1%	17%	22%

The age categories were changed in FY 95 to those listed above. The previous categories included Children aged 0-6, Children aged 7-17, Women aged 18-64, and all others.

PHC CONTRACTORS
FUNDING AMOUNTS, NUMBER OF CLIENTS SERVED, AND COUNTIES SERVED FY 2002

CONTRACTORS	YRS FUNDED BY PHC	DOLLAR AMOUNT	NUMBER SERVED PER ANNUAL RPT	COUNTIES SERVED
REGION 1				
COMM HLTH CTR OF LUBBOCK [CHC]	(Since 88) 14	$194,012	439	LUBBOCK
SO PLAINS COMM ACTION ASSOC [CAP]	(since 87) 15	$249,407	608	DICKENS, CROSBY, GARZA, LAMB
SO PLAINS PUBLIC HLTH DIST [LHD]	(since 90) 12	$356,834	646	GAINES, TERRY, YOAKUM
SO PLAINS RURAL HLTH SERVS [CHC]	(since 87) 15	$296,196	4532	COCHRAN, DAWSON, YOAKUM
REGION 2 & 3				
ABILENE-TAYLOR CO PUBLIC HLTH DIST [LHD]	(since 93) 9	$269,084	1434	TAYLOR
COMM HLTH SERVICE AGENCY, INC (3) [CHC]	(since 87) 15	$71,727	132	HUNT
CORSICANA-NAVARRO CO PUB HLTH DIST (3) [LHD]	(since 90) 12	$225,000	600	NAVARRO
CROSS TIMBERS HLTH CLINICS, INC [CHC]	(since 91) 11	$230,116	774	COMANCHE, EASTLAND, HAMILTON
DALLAS CO HOSP DIST COPC (3) [HOSP]	(since 87) 15	$306,262	1304	DALLAS
FISHER CO HOSP DIST [HOSP]	(since 97) 5	$106,121	398	FISHER
NO CENTRAL TEX COMMUNITY HEALTH CARE CENTER, INC [CHC]	(since 97) 5	$381,600	1170	ARCHER, CLAY, COTTLE, FOARD, HARDEMAN, JACK, KNOX, THROCKMORTON, BAYLOR, MONTAGUE, WICHITA, WILBARGER, YOUNG
PARKLAND FOUNDATION (3) [HOSP]	(since 02) 1	$193,017	0*	DALLAS
SHACKELFORD CO COMM RESOURCE CTR [PNP]	(since 97) 5	$98,000	468	SHACKLEFORD
TARRANT CO HOSP DIST (3) [HOSP]	(since 87) 15	$210,000	3596	TARRANT

CONTRACTORS	YRS FUNDED BY PHC	DOLLAR AMOUNT	NUMBER SERVED PER ANNUAL RPT	COUNTIES SERVED
REGION 4 & 5N				
ANGELINA CO & CITIES HEALTH DIST (5) [LHD]	(since 90) 12	$214,500	1522	ANGELINA, CHEROKEE, NACOGDOCHES, POLK, SABINE, SAN AUGUSTINE, TRINITY
EAST TX COMM HEALTH SERVICES (5) [CHC]	(since 95) 7	$298,542	645	NACODOCHES
EAST TX MEDICAL CTR – QUITMAN [PNP]	(since 98) 4	$280,500	956	UPSHUR, WOOD, VAN ZANDT
HEALTH EXTENSIONS BY LOCAL PHYSICIANS (HELP) (5) [PNP]	(since 87) 15	$200,000	307	HOUSTON, TRINITY
JASPER NEWTON CO PUB HLTH DIST (5) [LHD]	(since 87) 15	$330,000	1003	JASPER, NEWTON
LONGVIEW WELLNESS CENTER, INC. [PNP]	(since 02)	$120,000	363	GREGG
MEM MEDICAL CTR SAN AUGUSTINE (5) [HOSP]	(since 95) 7	$195,000	611	SAN AUGUSTINE
PARIS-LAMAR CO HEALTH DEPT [LHD]	(since 95) 7	$180,000	345	DELTA, FANNIN, HOPKINS, LAMAR, RED RIVER, TITUS
SAINT PAUL CHILDREN□S FOUNDATION, INC [PNP]	(since 99) 3	$276,574	724	SMITH, VAN ZANDT, RAINS, MORRIS, HENDERSON, CHEROKEE
TITUS CO MEMORIAL HOSP DIST [HOSP]	(since 97) 5	$111,680	628	TITUS, CAMP, MORRIS FRANKLIN, RED RIVER
REGION 5S & 6				
CHAMBERS CO PUBLIC HOSP DISTRICT dba BAYSIDE COMMUNITY HOSPITAL [HOSP]	(since 02)	$125,000	161	CHAMBERS
FT BEND FAMILY HLTH CTR, INC [CHC] WALLER	(since 87) 15 (since 02)	$601,533	3991	FORT BEND, WALLER
SAN JACINTO METHODIST HOSP [UNI/RES]	(since 87) 15	$330,000	811	HARRIS, LIBERTY, CHAMBERS
REGION 7				
BRAZOS VALLEY COMM ACTION AGENCY, INC [CHC]	(since 87) 15	$340,681	1486	BRAZOS

CONTRACTORS	YRS FUNDED BY PHC	DOLLAR AMOUNT	NUMBER SERVED PER ANNUAL RPT	COUNTIES SERVED
COMMUNITY ACTION, INC OF HAYS, CALDWELL, & BLANCO COUNTIES [CAP]	(since 87) 15	$230,000	411	BASTROP, BURNET, CALDWELL, BLANCO, HAYS, WILLIAMSON
LLANO MEM HEALTHCARE SYS-SAN SABA [PNP]	(since 95) 7	$225,000	547	BURNET, LLANO, SAN SABA
WILLIAMSON CO & CITIES HLTH DIST [LHD]	(since 88) 14	$360,000	1331	WILLIAMSON
REGION 8				
ATASCOSA (RHI) HEALTH CLINIC, INC [CHC]	(since 02)	$90,000	153	ATASCOSA
BARRIO COMP FAM HLTH CARE CTR, INC [CHC]	(since 88) 14	$162,604	267	BEXAR
COMMUNITY HEALTH DEVELOPMENT, INC. [CHC]	(since 02)	$90,000	328	EDWARDS, REAL, UVALDE
EL CENTRO DEL BARRIO [CHC]	(since 97) 5	$250,000	2225	BEXAR
GONZALES CO HEALTH AGENCY, INC [CHC]	(since 87) 15	$90,000	655	GONZALES
SOUTH TX RURAL HLTH SERVS, INC [CHC]	(since 87) 15	$87,161	388	LASALLE, DIMMIT, FRIO, MEDINA
UNITED MEDICAL CENTERS [CHC]	(since 87) 15	$561,967	11427	MAVERICK, VAL VERDE
REGION 9 & 10				
ANDREWS CO HEALTH DEPT [LHD]	(since 87) 15	$119,574	564	ANDREWS
CENTRO DE SALUD FAMILIAR LA FE (10) [CHC]	(since 96) 6	$230,123	1877	EL PASO
CENTRO SAN VICENTE (10) [CHC]	(since 95) 7	$369,169	3652	EL PASO
CONCHO VALLEY PROJECT [PHR]	(since 90) 12	$219,000	460	CONCHO, CROCKETT, KIMBLE, MASON, MCCULLOCH, MENARD, SCHLEICHER, SUTTON
ECHD-MEDICAL CTR HOSP- FAM HLTH CTR [HOSP]	(since 95) 7	$330,000	1592	ECTOR
MIDLAND CO HOSPITAL DISTRICT [HOSP]	(since 94) 8	$562,037	2382	MIDLAND
PECOS CO MEMORIAL HOSPITAL [HOSP]	(since 95) 7	$159,500	676	PECOS, TERRELL
PROJECT VIDA (10) [PNP]	(since 95) 7	$250,000	2056	EL PASO
RIO GRANDE PROJECT (10) [PHR]	(since 94) 8	$331,000	867	BREWSTER, CULBERSON, HUDSPETH, JEFF DAVIS, PRESIDIO

CONTRACTORS	YRS FUNDED BY PHC	DOLLAR AMOUNT	NUMBER SERVED PER ANNUAL RPT	COUNTIES SERVED
LA ESPERANZA CLINIC [CHC]	(since 88) 14	$300,240	833	TOM GREEN
REGION 11				
COMM ACTION CORP OF SOUTH TEXAS [CAP]	(since 87) 15	$641,135	2319	BROOKS, JIM WELLS, SAN PATRICIO
LOWER RIO GRANDE VALLEY COMM HLTH MANAGEMENT CORP, INC. [PNP]	(since 97) 5	$450,000	2042	HIDALGO
COMM ORIENTED PRIMARY CARE ASSOC, INC (CO P R I M A) [PNP]	(since 87) 15	$262,500	803	CAMERON
NUESTRA CLINICA DEL VALLE – HIDALGO [CHC]	(since 87) 15	$252,552	4140	HIDALGO
LAREDO (CITY OF) HEALTH DEPT [LHD]	(since 87) 15	$165,000	307	WEBB
SUB-TOTAL		$13,579,948	71,936	

SDI

DENTON CO HEALTH DEPT (3) **(SDI)** [LHD]	(since 93) 9	$220,184	5166	DENTON
SMITH CO PUBLIC HEALTH DIST (4/5) **(SDI)** [LHD]	(since 96) 6	$147,295	7058	SMITH
FAYETTE MEMORIAL HOSPITAL (7) **(SDI)** [HOSP]	(since 97) 5	$155,541	1819	FAYETTE, LEE
SUB-TOTAL		$523,020	14,043	
TOTAL		**$14,102,968**	**85,999**	

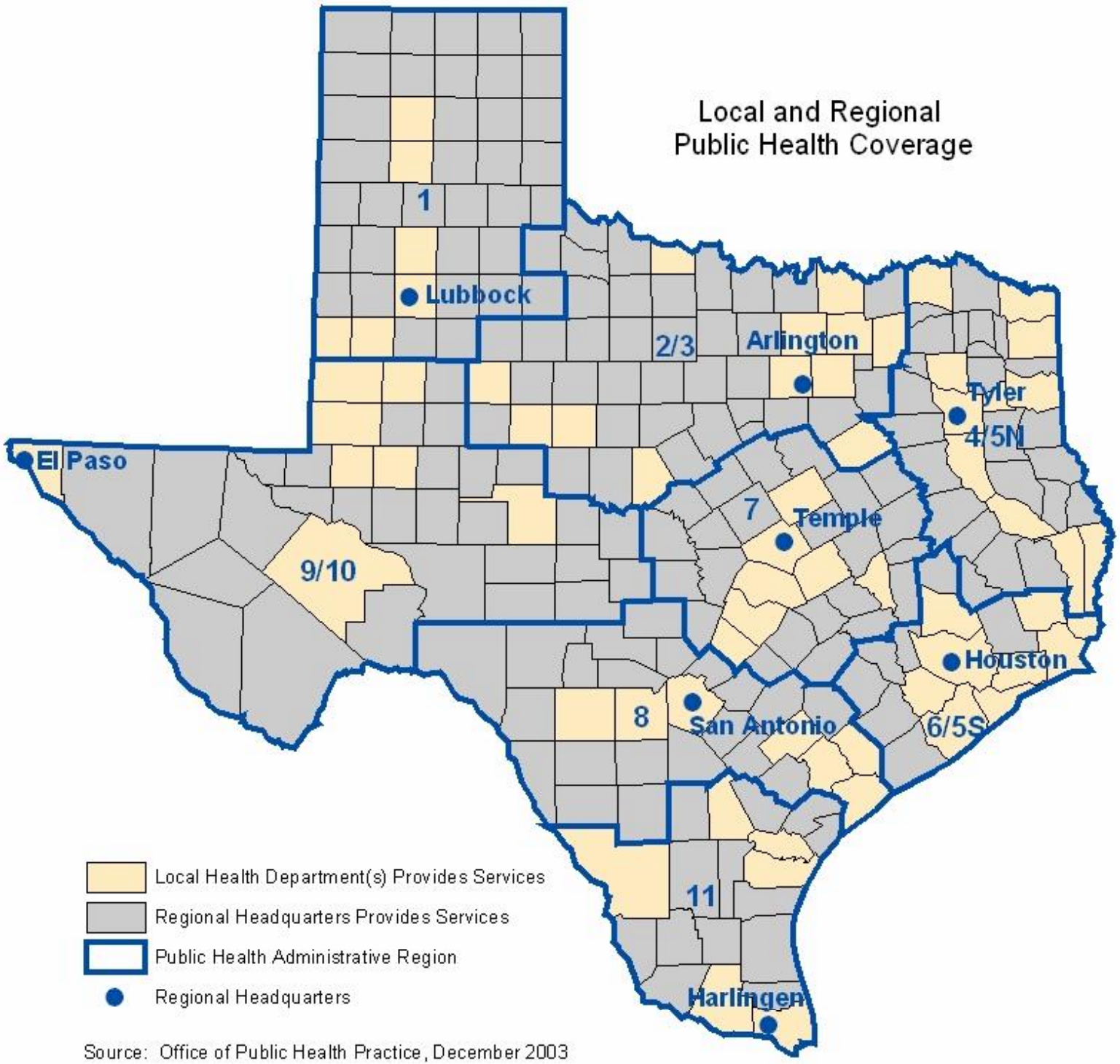
*Special Project does not report data comparable to other contractors. Data other than award is excluded from consideration.

PROVIDER CODES

CAP	Community Action Program (3)
CHC	Community Health Center (19)
HOSP	Hospitals/Hospital District (10)
LHD	City and/or Co Health Dept (9)
PHR	Public Health Region Administrative Unit of Texas Dept of Health (2)
	Total contracts 53
PNP	Private Nonprofit Organization (9)
UNI/RES	University Residency Programs (1)

HOSP	Hospitals/Hospital District (1)
LHD	City and/or Co Health Dept (2)
	Total contracts for SDI 3

Total all contracts 56


Local and Regional
Public Health Coverage
1
Lubbock
2/3
Arlington
Tyler
4/5N
El Paso
7
Temple
9/10
Houston
8
San Antonio
6/5S
11
Harlingen
Local Health Department(s) Provides Services
Regional Headquarters Provides Services
Public Health Administrative Region
Regional Headquarters
Source: Office of Public Health Practice, December 2003