TEXAS DEPARTMENT OF HEALTH

PRIMARY HEALTH CARE PROGRAM

Annual Report

Fiscal Year 2003

Bureau of Community Health Resources
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 Guidelines (FPG) and who do not qualify for any other programs or benefits provide the same services.

In FY 2003, the PHC program distributed $14,157,250 in state-allocated funds to 56 contractors across the state. Every public health region had from three to 11 contractors. Services were provided in 136 counties and 91,565 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. Cost of $13,348,672 was incurred for 719,261 medical services. Non-medical services cost $2,588,678 to provide 306,888 services. An additional $2,195,659, 12% of all costs, was expended for administrative costs. The total expended amount of $18,133,009 on primary care services in FY 2003 demonstrates that state-allocated funds ($14,157,250) were supplemented by local funding and co-payments (program income) totaling $3,975,759. The average cost per PHC client in state-allocated funds in FY 2003 was $154.61.

PHC contractors may include local health departments, community action programs, community health centers, private non-profit organizations, hospitals or hospital districts, and government entities. 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. The Primary Health Care Services Act, H.B. 1844 authorized 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 Request for Proposal (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 presumptive eligible basis.

In addition to these eligible clients, PHC contractors impact the lives of many other Texans by providing a variety of population-based services, including the screening and eligibility process which allows appropriate referrals to be made to other local and state programs, and health education and outreach services provided such as health fairs and mass health risk screening.

Current Year Operations

In FY 2003, 56 PHC contractors provided services to 91,565 individuals in a 136 county service area (Table 1). Approximately 73% of the 136 counties served by the PHC Program in FY 2003 are designated as rural and the rest are designated as urban.[1]

Funding remained level from FY 1994 to FY 2003, 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. FY 2003 is the second year in the three-year process.

[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 2003

Region*	PHC Contractors+	Dollar Amount	Number Served	Counties Served
1	4	$1,096,449	7,658	8
2/3	11	$2,365,393	14,438	31
4/5	11	$2,354,091	12,510	32
6/5	3	$1,056,533	3,937	5
7	5	$1,311,222	6,379	17
8	7	$1,331,732	14,120	11
9/10	10	$2,870,643	21,368	24
11	5	$1,771,187	11,155	8
Total	**56**	**$14,157,250**	**91,565**	**136**

*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 (Table 2).

Table 2
Contractors by Organization Type
FY 2003

Organization Types Providing PHC	**Number of Contractors**
City and/or County Health Departments	11
Community Action Programs	1
Community Health Centers	20
Hospitals or Hospital Districts	13
Public Health Region (Administrative Unit of TDH)	2
Private Nonprofit Organizations	9
Total	**56**

FY 2003 Annual Program Reports submitted by each contractor yielded information on the numbers of persons served by the program. In addition to the 91,565 unduplicated eligible clients provided with PHC medical and non-medical services, the contractors also provided screening and eligibility services and provided referrals to PHC and other programs for 193,088 persons.

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 $15,937,350 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 719,261 medical services were provided. The most frequent service was diagnosis and treatment either for the provision of medical services to minimize complications of chronic illness or for the one-time acute illness needing immediate care.

PHC contractors also provided 306,888 non-medical services to both PHC clients as well as non-eligible clients in FY 2003 (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.

Table 3
Breakdown of Medical Services Provided and Costs Charged to the PHC Grant
FY 2003

Medical Service Type	Total PHC Dollars Spent	Total Number of Medical Services Provided	Average Cost Per Service to PHC
Diagnosis & Treatment	$5,945,961	232,217	$25.61
Emergency Services	$76,637	1,290	$59.41
Family Planning	$168,256	2,709	$62.11
Preventative Health	$918,088	54,018	$17.00
Health Education			
# one-to-one sessions	$753,548	53,152	$14.18
# group sessions	$197,553	7,467	$26.46
Pharmacy	$2,281,476	160,578	$14.21
Laboratory	$1,521,590	150,591	$10.10
Other Diagnostic Tests	$731,455	11,573	$63.20
Dental Services	$269,006	12,690	$21.20
SDI Contractors*	$485,102	32,976	$14.71
Grand Total	$13,348,672	719,261	$18.56

* Data management system – SIEBRS (SDI Integrated Eligibility Billing and Reporting System) for the three SDI contractors reports information by CPT code, therefore the total number of medical services cannot be separated by category and are listed separately

Table 4
Breakdown of Non-Medical Services Provided and Costs Charged to the PHC Grant
FY 2003

Service Type	Total PHC Dollars Spent	Total Number of Non-Medical Services Provided	Average Cost Per Service to PHC
Screening and Eligibility	$1,873,761	196,678	$9.53
Transportation	$69,398	7,151	$9.70
Counseling Case Management	$645,519	103,059	$6.26
Grand Total	$2,588,678	306,888	$8.44

The contractors reported total expenditures of $15,937,350, for the medical and non-medical services detailed in Tables 3 and 4, and an additional $2,195,659 expended for administrative costs (12%). This represents a reported total PHC program cost of $18,133,009 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 $3,975,759 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 10 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 2003 as their primary process objective. According to data submitted on the "Performance Indicators Report Summary" for FY 2003, 27 (50%) of the contractors met or exceeded the number of unduplicated individuals they targeted to serve in their RFP response. An additional 12 (22%) 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 skills 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.

- 83% of the PHC contractors identified diabetes
- 66% 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-four percent (54%) 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.

Fifty-eight percent (58%) of the impact objectives met was related to diabetes management. The other forty-two percent (42%) 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 FY 2003

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 in FY 2003, 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.

South Plains Community Action Association, Inc. (PHR 1) serving clients in nine counties with clinics in Dickens, Crosby, and Garza. Services offered include diagnosis and treatment, minor office emergency treatment, one-on-one health education and adult preventive health services. Other preventive services include child health, family planning, prenatal, and immunizations. Assistance is also provided to PHC clients as needed by making referrals to specialty healthcare providers in the region. PHC staff has been successful in arranging for some specialty care providers, including mental health care providers, to routinely come to the Spur Clinic to provide on-site services, thus avoiding the clients having to drive up to 170 miles round trip to obtain these services.

Abilene-Taylor County Public Health District (PHR 2) serving clients with comprehensive physical exams, assessments and referrals to appropriate specialty providers in Taylor County. Clients are urged to use the clinic as their medical home versus the Trauma Center. Dental care is needed for children and adults. PHC funds have served as the catalyst for the establishment of an array of services available directly from the Family Health Center, the Health District or by referral to other agencies. Mental health services have been hampered by a reduction in available services through the Texas MHMR Department.

Cross Timbers Community Health Center (PHR 2) serving clients in Comanche, Eastland, and Hamilton Counties. The center has a successful diabetic project that provides monthly visits, diabetic supplies, and glucometers. The clients are educated on proper diet, exercise, and lifestyle changes. The center subcontracts with a podiatrist and has several different types of specialists who rotate such as dentists, dietitians, and optometrists. The PHC program offers both health promotion and preventative health practices to a population whose health care needs would otherwise be unmet.

Community Health Service Agency, Inc. (PHR 3) serves clients of Fannin and surrounding counties in North Central Texas. The PHC Program has linkage with the Texas A&M Counseling centers and is meeting with the MHMR Services of Texoma to formulate a plan to integrate mental health services. Community Health Services

Agency, Inc (CHSA) continues to offer comprehensive medical care as well as primary and preventative care. The patients are integrated into CHSA delivery system to assure prenatal care & delivery, after hours and emergency care, in patient care, and dental care. The population presents primarily with chronic disease and the needs are extensive.

Corsicana-Navarro Co. Public Health District (PHR 3) serves clients of Navarro County. The PHC services have been linked with other health and human service providers such as County Indigent Health Care, Family Services, Department of Human Services and the local food pantry. Many clients with chronic diseases such as diabetes and hypertension have been served. Specialty care is available by referral only to PHC clients at a local clinic at no charge. Case management is done in an informal manner to ensure that needs are being met if the resources are available. The challenge remains to enable low-income, uninsured citizens a place to receive medical care.

East Texas Medical Center – Quitman (PHR 4) covers Wood, Upshur, and Van Zandt Counties. The services available include diagnosis, treatment, family planning services, preventative health services, health education and laboratory services utilizing bilingual staff. For services not available, the patients are referred to ETMC Quitman Hospital and a follow-up report is sent back for the patient's record. Diabetic Eye Program exams are done by Mineola Eyecare Associates. The PHC program closes the gap in medical services by drastically lowering the cost of primary and preventative medical services and by not refusing services due to an inability to pay. The center believes that there are improvements that still need to be made to meet the needs of the community.

Longview Wellness Center, Inc (PHR 4) serves clients in 10 counties. This clinic works with the Gregg County Health Department to ensure that patients receive care regardless of their eligibility status. The clinic has a Pharmaceutical Patient Assistance Program that is very cost effective. Many of the PHC patients have extensive medical needs including ongoing monitoring and treatment for chronic conditions. Case management for prenatal and infants is also provided. Linkages to community resources providing assistance have been created.

Angelina County & Cities Health District (PHR 5) serves Angelina and five surrounding counties. The PHC focus is on hypertension, diabetes, women's health, and depression. The clinic began a Class D Pharmacy in FY 2003 to dispense medications directly to the patients. Clients are referred for specialty care to a network of local specialists. The PHC funds enable the District to expand services to a broader base of individuals. They continue to strive to make their facilities user friendly.

Healthcare Extensions by Local Physicians, Inc. (H.E.L.P.) (PHR 5) is delivering services to Houston and Trinity Counties. For 17 years H.E.L.P. has served as an extension of TDH by increasing the access services through outreach, assessment, education, and referrals. Referrals are made as determined by the health risk assessments. Diabetics are referred to a local optometrist for annual diabetic eye exams. Many referrals have been made to prescription drug programs. The agency is a network provider; therefore the program faces many challenges, such as maintaining subcontracts with local providers that clinical settings may not experience.

San Jacinto Methodist Hospital (PHR 6) is serving Liberty, Harris, and Chambers Counties. This program trains family practice physicians who will serve in the rural areas of Texas through clinical operations in Chambers and Liberty and east Harris Counties. The services provided include diagnostic/therapeutic services, psychological services, patient education, diabetic teaching classes, specialist services, pharmacy, dental and ophthalmologic services. Specialty medical care is offered to the patients through contacts with specialty medical personnel. The type of model allows for a greater emphasis on community cooperation and participation for the greater good of the defined patient population.

Llano County Hospital Authority (PHR 7) serves San Saba, Llano, and Burnet Counties. Diagnosis and treatment, prevention, obstetrics, pediatrics, geriatrics, family planning, and minor emergency services are offered. Podiatry services, dental services, and pharmacy services are subcontracted out. The most challenging aspects of the program continue to be the growing need for prescription services for the community residents and being able to provide PHC services to the end of the contract year without running out of state funding.

Community Health Development, Inc. (PHR 8) serves Uvalde and Zavala Counties offering primary medical care services, on-site diagnostic lab and x-ray, oral health services, family planning, specialty care referrals, Class D pharmacy, education/screenings, and social services. They also started prenatal care and obstetrical services. Specialty care is referred out. Evening and weekend hours have been added this year. This agency is challenged because half of their patients are uninsured.

Community Health Centers of South Central Texas, Inc. (PHR 8) serves 8 counties offering services in behavioral health, family practice, and women's health. A dental program is scheduled to begin in 2004. The medical and case management referrals are made according to patient needs. A licensed clinical psychologist is now on staff to provide comprehensive testing, individual and family therapy, drug and alcohol counseling as well as providing community education and outreach activities. Without the PHC funding, medical needs will go unmet.

Andrews County Health Department (PHR 9) offers comprehensive primary health care services in Andrews County. They have used PHC funds to expand linkages and cooperative efforts between existing Health and Human Services providers and enhance the providers' ability to meet the locally determined needs. Specialty care, dental, optometry, laboratory, x-ray, diagnostic tests, and pharmacy services are referred out. They have been successful in increasing the number of clients who use the indigent drug program, and linking clients to Title V services.

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 as the Community Voices of El Paso. They offer core primary preventive medical services, health education, social services, prenatal care, and case management. Services not

provided within the agency are referred out. Specialty care is provided through referrals to Texas Tech University Health Sciences Center and R.E. Thomason Hospital.

City of Laredo Health Department (PHR 11) serves Webb County by offering diagnostic and treatment services, preventive health services, health education, prescriptions, laboratory tests, medical referrals, and screening and eligibility services. Clients diagnosed with diabetes or hypertension are given education, counseling, and monitored. The staff attempts to provide as many preventive services as possible in order to decrease the incidence of chronic diseases in the community. The challenge has been maintaining an adequate staffing level due to funding cuts.

Nuestra Clinica del Valle (PHR 11) provides a medical home and educates patients on comprehensive diagnostic and treatment services in Hidalgo and Starr Counties. This clinic is able to participate in the Drug Assistance Program that is crucial to the patients served. The increasing numbers of uninsured, undocumented and their families place a heavy burden on resources.

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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 FY 2003 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 2003 operating year, 16 health fairs/screenings were held covering the required counties. Sixteen pediatric and 11 adult immunizations clinics were held at the request of the local communities, resulting in 1,091 pediatric and 575 adult immunizations. Primary care was provided to 551 unduplicated individuals. Thirty-five referrals to specialists and 13 referrals to emergency rooms were made.

Parkland Senior Care Grant

The Parkland Foundation, an agent for the Parkland Memorial Hospital, has a geriatric-focused program that was initiated in 1982 and has continued to expand. 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.

Grant planning efforts were initiated in December 2001, but actual operational efforts were undertaken in February 2002. The program remains under the leadership of Sharon Phillips, Vice-President of Parkland's Community Oriented Community Clinic programs. Operationally it is being managed by the Department of Geriatrics. Additional program support has been provided by staff from the following areas: Parkland Strategic Planning, Community Oriented Primary Care (COPC) Community Outreach, COPC MOM Mobile, COPC Accounting; staff from the Parkland Foundation; and geriatric physician leadership from the University of Texas Southwestern Medical Center.

During FY 2003, program services included:

- Case Management (low intensity and high intensity)
- Education programs and outreach efforts for seniors
- Senior Care Days
- Community involvement/outreach with community health, civic, human service providers
- Van transportation
- Senior safety item distribution

Low intensity case management services were provided to 173 clients. Low intensity services includes the providing an overview of Parkland services to clients, meeting with Parkland patients individually to determine their primary care provider, next appointment, transportation need, and identifying other support issues. High intensity services were provided to 65 clients. High Intensity Case Management outreach services were provided to elders who are not being served by medical and social services, who are no longer able to access those services, and/or who require special outreach efforts. Parkland assisted in identification of these individuals through area churches, senior centers, and other senior agencies (like Access Center for the Elderly, Senior Citizens of Greater Dallas, City of Dallas Senior Affairs Office, Aging Information). Therefore, a total of 238 clients were provided case management services.

Twenty-five education programs were provided on such topics as nutrition, medication safety, Alzheimer's disease, fall safety, and health promotion. There was one community health outreach event held each month. There were nine events of on-site education, health screening and case management at "Senior Care Days". Community involvement and outreach with community-based organizations happened monthly. The van transportation had 550 round trips. There was 1,300 safety items distributed to seniors. The senior focus group input and individual case management experience was used to determine the use for the unspecified funds used by the Parkland Senior Outreach Services staff. A positive response to the van transportation service and program staff was apparent by the analysis of survey responses.

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 Guidelines. PHC clients live in every region of the state. While some are employed, most 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 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 FY 2003 was estimated at 865,975. This reflects a decrease compared to FY 2002 in the numbers of persons estimated eligible for PHC by approximately 370,939. Although fewer had employer group insurance or other private insurance, more were enrolled in Medicaid and the County Indigent Health Care Program (CIHCP).

In FY 2003, PHC contractors reported serving 91,565 unduplicated clients, or 11% of the estimated target population. In comparing the percentage of persons served in FY 2002 (7%) to FY 2001 (4.15%) and FY 2000 (4.5%), contractors provided services to more of the estimated eligible population. This finding is the result of not only the decrease in the estimated number of the target population but changes in the PHC Program policy that allowed for the counting of all presumptive eligible clients. Presumptive eligibility was begun in FY 2003 to allow services to be given when an immediate medical need, as determined by a medical provider, existed and clients screened as potentially eligible but did not have all documentation available for full enrollment.

Table 5
Target Population of the PHC Program
FY 2003

Estimated number of persons in Texas at or below 150% of poverty[1]	5,659,938
Estimated number of Texans below 150% of poverty with employer group insurance or other private insurance, excluding Medicaid and Medicare[2]	1,809,077
Average monthly enrollment in Medicaid (all programs)[3]	2,380,285
Estimated number of Texans below 150% of poverty with only Medicare coverage[4]	579,417
Estimated number of individuals in FY 03 enrolled in the County Indigent Health Care Program (CIHCP)[5]	25,184
Estimated target population of the Primary Health Care Program	865,975

[1] Texas Department of Health, Bureau of Vital Statistics, Texas A&M University, Texas State Data Center, 2002 Population Estimates, May 2002.
U.S. Census Bureau, Census 2000, SF4, Table PCT144, reformatted by TDH, Center for Health Statistics so that percentages are cumulative. Source table reports discrete categories.

[2] U.S. Bureau of the Census, Current Population Reports, Health Insurance Coverage: 2002, September 2003.
Texas Health and Human Services Commission, Demographic Profile of the Texas Population Living in Poverty in 2001. Research Department, 2003

[3] Texas Department of Human Services, Monthly Medicaid Eligible File Extract, FY2003. 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 2002.

[5] Texas Department of Health, County Indigent Health Care Program, FY 2003

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 legislatively mandated TDH initiative to streamline direct health care delivery for programs, contractors and clients. This has been accomplished through the integration of policies and the development of the automated business system that screens and refers, determines eligibility, uses single data entry, and has real time billing and reporting with weekly reimbursement. Clients have a single enrollment and eligibility for numerous programs subject to the availability of in-scope funding sources, such as Title V and PHC. Due to the integrated policies a client is not determined eligible for a single funding source but eligible for all in-scope funding sources the contractor has available. Demographics are collected on all clients served by the three SDI contractors.

Poverty Level of PHC Clients Served in FY 2003

The majority (58%) of PHC clients served in FY 2003 live at or below 100% of the federal poverty income limits (Table 6).

Table 6

Poverty Level of PHC Clients Served FY 2003

Percent of Poverty	Number of Clients Served	Percentage
151% - 185%	385	0.5%
150% - 126%	19,729	21.5%
125% - 101%	16,610	18.2%
100% - 76%	18,975	20.7%
75% - 51%	14,591	15.9%
50% - 26%	8,359	9.1%
25% - 0%	11,544	12.6%
Missing Data *	1,372	1.5%
Total	**91,565**	**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.

Race Data

Race data are collected when medical services are provided. While all races are represented among the PHC program clients served (Table 7/8), the majority of clients served (69%) reported themselves as Hispanic. This reflects an increase in the reported Hispanic share of the population served from 57.2% in FY 2002 and 62% reported in FY 2001. 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 2003

Race	Number of Clients	Percentage
White	71,602	78.2%
Black or African American	6,735	7.4%
American Indian or Alaskan Native	64	0.1%
Asian	736	0.8%
Native Hawaiian or other Pacific Islander	38	0.0%
Unknown	11,639	12.7%
Missing	751	0.8%
Total	**91,565**	**100.0%**

Table 8
PHC Clients Served by Ethnicity
FY 2003

Ethnicity	Number of Clients	Percentage
Hispanic	62,939	68.7%
Non Hispanic	23,795	26.0%
Not Available	4,080	4.5%
Missing	751	0.8%
Total	**91,565**	**100.0%**

Educational Level

Information on education level is collected only from the clients aged 18 years or older who receive a medical service (Table 9). This information is optional and in FY2003, the Program observed a decrease in the numbers of clients served who were reported as the "did not specify" category for this information. An increase was reported in the "high school diploma or equivalency" and "had more than a high school diploma" categories.

Table 9
PHC Clients Served by Education Level
FY 2003

Education Level	Percentage
Clients with less than a High School Diploma	5.6%
Clients a High School Diploma or equivalency	27.7%
Clients with more than a High School Diploma	40.0%
Clients did not specify an education level	26.7%
Total	**100%**

Gender and Age

In total, the majority of PHC clients served in FY 2003 were female (Table 10), 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 more than half of PHC clients aged 18 or older reported themselves as unemployed (53%). See Table A in the Appendix for summary highlights of PHC program data from FY 1993 –2003.

Table 10
Gender by Age of PHC Clients Served
FY 2003

Age	Percent Male	Percent Female
Less than one year	43.5	56.5
Ages 1 – 4	46.9	53.1
Ages 5 – 12	47.2	52.8
Ages 13 –19	46.0	54.0
Ages 20 – 64	29.6	70.4
Ages 65 and older	39.9	60.1

Client Satisfaction Surveys

In FY 2003, 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 (Table 11). 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 instructed to summarize the responses quarterly.

Completion of the surveys is voluntary, and it is an option for any client to participate. Results from FY 2003 do not vary significantly from the results of the same survey tool used in FY 2002. Approximately 74.1% of clients completing the surveys are returning (rather than new) clients, and 68.7% have an established appointment for their visit. Of those without appointments, 74.9% report being able to be seen by a provider in the clinic on the same they arrived for a service. Approximately 93.2% either agree or strongly agree they have received high quality health care and only 24.7% report going to another provider or location for their health care needs.

The tabulated results from the survey are as follows:

Table 11
Client Satisfaction Survey Results
FY2003

Survey Question	Summary Results	
Is this your first visit to the clinic?	Yes	24.8%
	No	74.1%
	Not Sure	1.1%
If yes, were you seen within two weeks of your first call?	Yes	68.9%
	No	24.2%
	Not Sure	6.9%
Did you have an appointment for your clinic visit today?	Yes	68.7%
	No	30.4%
	Not Sure	0.9%
If you had no appt., were you seen the same day?	Yes	74.9%
	No	20.8%
	Not Sure	4.3%
Do you pay any money for the services you get at this clinic?	Yes	59.2%
	No	36.3%
	Not Sure	4.5%
Who is being seen at the clinic today?	72.1% Myself	1.8% Children
	7.1% Spouse	1.6% Parents
	0.8% Domestic Partner	0.9% Friend
	14.3% Child	1.4% Other
What services did this person(s) get today?	23.4% Saw the Doctor	1.3% Cardiac Care
	14.3% Saw the Nurse	4.5% Routine Physical
	6.0% Picked up Medications	3.4% Pre-natal services
	8.0% Lab or Blood work	8.8% Intake appointment
	9.8% Blood Pressure check	3.8% Immunization/flu shot
	2.8% Cholesterol Screening	7.9% Other
	6.0% Diabetes check up	
This clinic provides me with high - quality health care.	Strongly Agree	50.3%
	Agree	42.9%
	Neither Agree nor Disagree	5.1%
	Disagree	1.0%
	Strongly Disagree	0.7%
Does this clinic meet your medical needs?	Yes	91.2%
	No	5.0%
	Not Sure	3.8%
Do you go anywhere else for your health care?	Yes	24.7%
	No	72.1%
	Not Sure	3.2%

FUTURE DIRECTIONS

Expansion of Federally Qualified Health Centers

The health care crisis is not unique to the state of Texas. This issue is being addressed at the federal level through the efforts of President George W. Bush's initiative to double the number of Federally Qualified Health Centers (FQHC) over the next five years. The 78th Texas Legislature allocated $5 million in appropriated funds for both FY04 and FY05 to support the Texas Department of Health's FQHC Incubator Program. This program will assist communities in developing a viable community health center to meet the growing needs of the indigent population and align them to favorably receive part of the $114 million federal funding available through the Federal Bureau of Primary Care.

PHC Contractor Performance Measures

Outcome performance measures linked to Healthy People 2010 objectives were developed by each contractor in FY02 and will continue to be tracked through FY04 to objectively assess the impact and effectiveness of projects on the medical needs of their client population. The contractor's process (number of clients served) and impact (measurable changes in health behavior) performance measures improved during FY03 and it is expected that this trend will continue into FY04.

Grant Process – Third and Final Year of Competitive Cycle

FY04 will be the last of the three-year competitive grant. Efforts will be made to attract new providers within areas not formerly served so that the more providers will apply for PHC funding in FY05 and thus expand the number of counties served. Contractors will continue to partner with other agencies in their community so that access to health care will be readily available. Many existing contractors already have the infrastructure in place in their communities to increase access to health care. One missing ingredient in their attempt is additional funding to assure care for all.

PHC Stakeholder Process

Program staff will hold a series of stakeholder meetings early in FY 2004 to obtain input in revising the program to continue to meet needs given limited funding. FY 2004 will require further implementation of cost-saving measures since there will be a slight reduction in contractor awards in FY 2004 due to a decrease in appropriated funding from the 78th Legislature.

Health and Human Services Consolidation

HB2292 from the 78th Texas Legislature directed Texas health and human services agencies to consolidate organizational structures and functions, eliminate duplicative administrative systems, and streamline processes and procedures that guide the delivery of health and human services to Texans. Although some policies and procedures have been streamlined over the past two years so that the Primary Health Care Program and

Title V Fee-for-service Program have similar procedures, additional steps will be taken during the consolidation process to merge additional client service programs so that a seamless system of care both the provider and the recipient of care can become a reality.

Appendix

TABLE A **Highlights of Primary Health Care Program Data in Fiscal Years 1993-2003**

CATEGORY	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03
Total clients served	73,126	98,780	100,563	109,059	107,308	87,719	85,858	89,443	85,247	85,999	91,565
Cost per client (including all types of service)	$114.29	$111.72	$123.62	$118.76	$128.47	$150.19	$150.33	$178.56	$194.79	$163.99	$154.61
Cost per Diagnosis &Treatment service only	$22.49	$25.07	$24.10	$24.03	$26.54	$21.80	$21.44	$22.18	$21.17	$21.09	$25.61
Cost per medical service	$11.16	$14.04	$15.08	$14.94	$17.99	$16.80	$17.98	$26.47	$18.19	$17.39	$18.58
Total services provided	650,675	668,363	705,682	773,359	670,915	784,060	810,298	603,339	643,069	712,764	993,173
No. of clients screened and referred to all programs	121,718	162,629	173,347	158,197	161,580	157,026	165,799	156,581	131,564	105,167	193,088+
No. referred to Medicaid	17,646	23,616	42,048	60,093	64,568	67,574	68,078	63,123	60,288	*	*
No. referred to CIHCP	20,769	23,080	17,386	16,116	16,553	19,401	13,204	12,584	13,817	*	*
Clients at or below 100% FPIL	76%	79%	77%	75%	72%	70%	73%	67%	56%	54%	59%
Unemployed Clients (age adjusted)	61%	61%	57%	54%	51%	45%	47%	48%	51%	39%	53%
Clients Served:											
Less than 1 year	w	w	1%	1%	1%	1%	1%	1%	2%	1%	0.4%
Age 1 – 4	w	w	3%	4%	5%	5%	5%	4%	4%	3%	2.4%
Age 5 – 12	w	w	11%	12%	11%	12%	11%	10%	9%	7%	6.6%
Age 13 – 19	w	w	28%	28%	18%	18%	12%	12%	9%	7%	6.9%
Age 20 – 64	w	w	51%	50%	59%	58%	65%	66%	69%	73%	76.3%
Age 65 and older	w	w	6%	5%	6%	6%	6%	7%	7%	8%	7.4%
Ethnicity:											
Hispanic	58%	58%	60%	64%	70%	67%	74%	74%	62%	57%	68.7%
White, not-Hispanic	21%	23%	21%	19%	18%	19%	17%	17%	15%	16%	74.5%
African American	19%	17%	16%	15%	10%	11%	7%	8%	6%	5%	6.8%
All other/Missing Data	2%	2%	3%	2%	2%	3%	1%	1%	17%	22%	18.7%

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.

- Information no longer collected

\+ SDI Contractor information not available.

TABLE B

PHC CONTRACTORS FUNDING AMOUNTS, NUMBER OF CLIENTS ENROLLED, & COUNTIES SERVED FY 03					
CONTRACTORS	**ENTITY**	**YRS FUNDED BY PHC**	**DOLLAR AMT**	**PER AR**	**COUNTIES SERVED**
REGION 1					
Comm Hlth Ctr of Lubbock Inc	CHC	(Since 88) 15	$ 194,012	2721	Lubbock
So Plains Comm Action Association, Inc	CAP	(Since 87) 16	$ 249,407	671	Crosby, Dickens, Garza
So Plains Public Hlth Dist	LHD	(Since 90) 13	$ 356,834	805	Dawson, Terry, Yoakum
So Plains Rural Hlth Services, Inc	CHC	(Since 87) 16	$ 296,196	3461	Cochran, Dawson, Yoakum
SUB-TOTAL			**$ 1,096,449**	**7658**	
REGIONS 2/3					
Abilene Public Health Department	LHD	(Since 93) 10	$ 269,084	1447	Taylor
Cross Timbers Health Clinic Inc	CHC	(Since 91) 12	$ 230,116	1828	Comanche, Eastland, Hamilton
Fisher County Hospital District	HOSP	(Since 97) 6	$ 106,121	415	Fisher, Kent, Nolan
North Central TX Comm Hlth Care Ctr	CHC	(Since 97) 6	$ 381,600	947	Archer, Baylor, Clay, Cottle Foard, Hardeman, Jack, Knox, Montague, Throckmorton, Wichita, Wilbarger, Wise, Young
Shackelford Co Comm Resource Ctr	PNP	(Since 97) 6	$ 98,000	580	Shackelford
Comm Hlth Service Agency Inc	CHC	(Since 87) 16	$ 71,727	585	Fannin, Hunt
Corsicana Navarro Co Public Hlth Dist	LHD	(Since 90) 13	$ 225,000	636	Navarro
Dallas Co Hosp Dist	HOSP	(Since 87) 16	$ 306,262	1947	Dallas
Parkland Foundation	HOSP	(Since 02) 1	$ 247,299	0	Dallas
Tarrant County Hospital Dist	HOSP	(Since 87) 16	$ 210,000	4072	Denton, Hood, Johnson, Parker, Tarrant, Wise
SUB-TOTAL			**$ 2,145,209**	**12457**	
REGIONS 4/5N					
East TX Medical Ctr - Quitman	HOSP	(Since 98) 5	$ 280,500	1009	Upshur, Van Zandt, Wood
Longview Wellness Ctr, Inc	PNP	(Since 02) 1	$ 120,000	402	Gregg, Harrison, Panola, Rusk, Upshur
Paris-Lamar County Health Department	LHD	(Since 95) 8	$ 180,000	1176	Delta, Fannin, Hopkins, Lamar, Red River, Titus
St. Paul Children's Foundation, Inc	PNP	(Since 99) 4	$ 276,574	0	Cherokee, Henderson, Marion, Morris, Panola, Rains, Smith, Van Zandt
Titus Co Mem Hosp	HOSP	(Since 97) 6	$ 111,680	594	Camp, Franklin, Morris, Red River, Titus

PHC CONTRACTORS FUNDING AMOUNTS, NUMBER OF CLIENTS ENROLLED, & COUNTIES SERVED FY 03					
CONTRACTORS	**ENTITY**	**YRS FUNDED BY PHC**	**DOLLAR AMT**	**PER AR**	**COUNTIES SERVED**
Angelina Co & Cities Hlth Dist	LHD	(Since 90) 13	$ 214,500	1751	Angelina
East TX Comm Hlth Services, Inc	PNP	(Since 95) 8	$ 298,542	845	Nacogdoches
Hlthcare Extensions by Local Phys, Inc	PNP	(Since 87) 16	$ 200,000	939	Houston, Trinity
Jasper-Newton Co Public Hlth Dist	LHD	(Since 87) 16	$ 330,000	1051	Jasper, Newton
Mem Medical Ctr - San Augustine	HOSP	(Since 95) 8	$ 195,000	2633	Angelina, Nacogdoches, Newton, Panola, Sabine, San Augustine, Shelby
SUB-TOTAL			**$ 2,206,796**	**10400**	
REGION 6					
Chambers-Bayside Comm Hosp	HOSP	(Since 02) 1	$ 125,000	317	Chambers
Fort Bend Family Hlth Ctr, Inc	CHC	(Since 87) 16	$ 601,533	2884	Fort Bend, Waller
Fort Bend and Waller together		(Since 02) 1			
San Jacinto Methodist Hosp	HOSP	(Since 87) 16	$ 330,000	736	Chambers, Harris, Liberty
SUB-TOTAL			**$ 1,056,533**	**3937**	
REGION 7					
Brazos Valley Comm Action Agency Inc	CHC	(Since 87) 16	$ 340,681	3117	Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington
Community Action, Inc.	CHC	(Since 87) 16	$ 230,000	378	Bastrop, Blanco, Caldwell, Hays
Llano Bay Health Care	CHC	(Since 95) 8	$ 225,000	523	Burnet, Llano, San Saba
Williamson Co & Cities Hlth Dist	LHD	(Since 88) 15	$ 360,000	1621	Williamson
SUB-TOTAL			**$ 1,155,681**	**5639**	
REGION 8					
Atascosa (RHI) Health Clinic	CHC	(Since 02) 1	$ 90,000	1026	Atascosa
Barrio Comp Family Hlth Care Ctr Inc	CHC	(Since 88) 15	$ 162,604	993	Bexar
Comm Hlth Ctrs of So Central TX-Gonzales	CHC	(Since 87) 16	$ 90,000	692	Gonzales
Community Health Development	CHC	(Since 02) 1	$ 90,000	530	Uvalde, Zavala
El Centro Del Barrio, Inc.	CHC	(Since 97) 6	$ 250,000	4094	Bexar
South Texas Rural Health Services	CHC	(Since 87) 16	$ 87,161	315	Dimmit, Frio, La Salle, Medina
United Medical Centers	PNP	(Since 87) 16	$ 561,967	6470	Maverick, Val Verde
SUB-TOTAL			**$ 1,331,732**	**14120**	

PHC CONTRACTORS FUNDING AMOUNTS, NUMBER OF CLIENTS ENROLLED, & COUNTIES SERVED FY 03					
CONTRACTORS	**ENTITY**	**YRS FUNDED BY PHC**	**DOLLAR AMT**	**PER AR**	**COUNTIES SERVED**
REGIONS 9/10					
Andrews City-County Health Department	LHD	(Since 87) 16	$ 119,574	425	Andrews
La Esperanza Clinic, Inc.	CHC	(Since 88) 15	$ 300,240	651	Coke, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Reagan, Schleicher, Sterling, Sutton, Tom Green
Medical Ctr Hosp - Family Health Center	HOSP	(Since 95) 8	$ 330,000	4452	Ector
Midland County Hospital District	HOSP	(Since 94) 9	$ 562,037	2526	Midland
Pecos County Memorial Hospital	HOSP	(Since 95) 8	$ 159,500	1161	Pecos, Terrell
TDH-Region 9/10-Concho Valley Project	PHR	(Since 90) 13	$ 219,000	323	Concho, Crockett, Kimble, Mason, McCulloch, Menard, Schleicher, Sutton
Centro De Salud Familiar La Fe Inc	CHC	(Since 96) 7	$ 230,123	1201	El Paso
Centro San Vicente	PNP	(Since 95) 8	$ 369,169	7490	El Paso
Project VIDA	PNP	(Since 95) 8	$ 250,000	2397	El Paso
TDH-Region 9/10-Rio Grande Project	PHR	(Since 94) 9	$ 331,000	742	Brewster, Culberson, Hudspeth, Jeff Davis, Presidio
SUB-TOTAL			**$ 2,870,643**	**21368**	
REGION 11					
City of Laredo Health Department	LHD	(Since 87) 16	$ 165,000	639	Webb
Comm Action Corporation of So TX	CHC	(Since 87) 16	$ 641,135	2621	Brooks, Jim Wells, San Patricio
Comm Oriented Primary Care Assoc., Inc	PNP	(Since 87) 16	$ 262,500	745	Cameron
LRGV-Comm Hlth MGMT Corp, Inc	CHC	(Since 97) 6	$ 450,000	2326	Cameron, Hidalgo, Starr, Willacy
Nuestra Clinica Del Valle Inc	CHC	(Since 87) 16	$ 252,552	4824	Hidalgo
SUB-TOTAL			**$ 1,771,187**	**11155**	
GRAND TOTAL (PHC)			**$ 13,634,230**	**86734**	
Denton Co Health Department (SDI)	LHD		$ 220,184	789	Denton
Smith Co Public Health District	LHD		$ 147,295	6325	Anderson, Cherokee, Dallas, Gregg, Henderson, Kaufman, Rains, Rockwall, Rusk, Smith, Titus, Upshur, Van Zandt, Wood
Fayette Memorial Hospital (SDI)	HOSP		$ 155,541	2434	Fayette, Lee
SUB-TOTAL			**$ 523,020**	**9548**	

PHC CONTRACTORS FUNDING AMOUNTS, NUMBER OF CLIENTS ENROLLED, & COUNTIES SERVED FY 03					
CONTRACTORS	**ENTITY**	**YRS FUNDED BY PHC**	**DOLLAR AMT**	**PER AR**	**COUNTIES SERVED**
GRAND TOTAL WITH SDI			**$ 14,157,250**	**96282**	
PROVIDER CODES					
Community Action Program	CAP	1			
Community Health Center	CHC	20			
Hospitals/Hospital District	HOSP	12			
City and/or Co Health Dept	LHD	9			
Public Health Region	PHR	2			
Administrative Unit of TDH					
Private Nonprofit Organization	PNP	9			
Total contracts		**53**			
Hospitals/Hospital District	HOSP	1			
City and/or Co Health Dept	LHD	2			
Total contracts for SDI		**3**			
Total all contracts 56					

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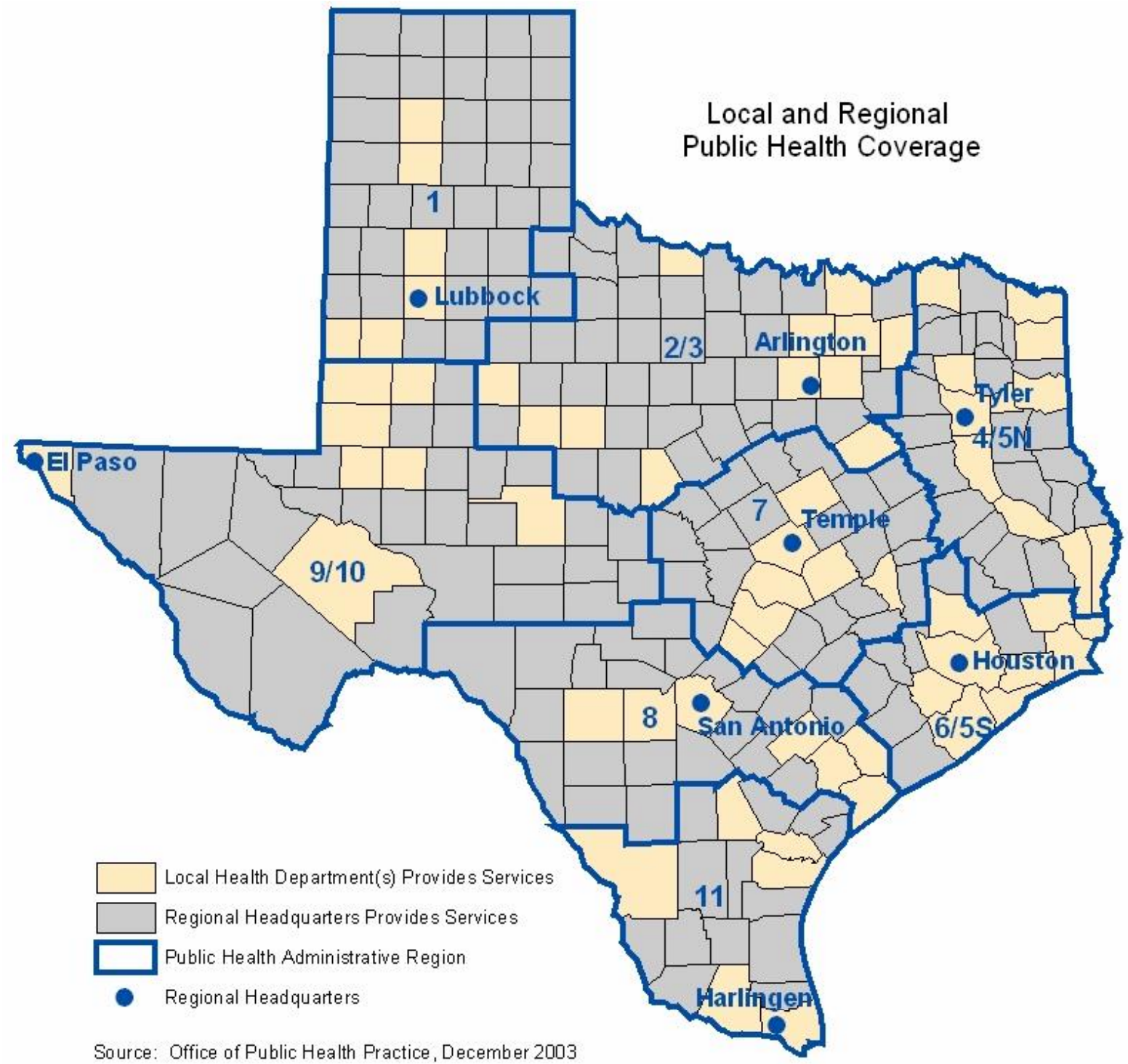
Local and Regional
Public Health Coverage
1
Lubbock
2/3
Arlington
Tyler
4/5N
El Paso
7
Temple
9/10
Houston
8
San Antonio
6/5S
11
Harlingen
Local Health Department(s) Provides Services
Regional Headquarters Provides Services
Public Health Administrative Region
Regional Headquarters
Source: Office of Public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