DEPARTMENT OF STATE HEALTH SERVICES

PRIMARY HEALTH CARE PROGRAM

Annual Report

Fiscal Year 2004

Community Health Services Section
Division for Family and Community Health

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EXECUTIVE SUMMARY

The Primary Health Care program (PHC), based in the Division for Family and Community Health at the Texas Department of State Health Services (DSHS), began in 1987 following the passage of H.B. 1844 by the 69th Texas Legislature.

PHC provides primary health care, including preventive health services and education to Texas residents who could not otherwise receive such care. Eligibility is limited to Texas residents whose gross family income is at or below 150 percent of the Federal Poverty Level (FPL) and who do not qualify for any other programs or benefits that provide the same services, such as Medicaid.

In FY 2004, 56 contracted providers expended $11,225,255 in state-allocated PHC funds across the state. Each of the 11 Health Service Regions (HSR) had at least three and up to 11 contractors. More than 77,500 unduplicated clients in 133 counties received primary health care services ranging from classes on improving health status to direct services for a one-time problem or a chronic condition. Including DSHS PHC funding, local funds, and program income, contractors incurred a cost of $12,610,873 to provide 693,785 medical services and a cost of $2,306,454 to provide 310,386 non-medical services. An additional $1,330,783 was expended by contractors to support administrative costs. Therefore, the total amount expended on primary health care services in FY 2004 was $16,248,110. Local funding and program income (client fees) amounted to $2,422,782 of the total amount expended. The FY 2004 average cost per PHC client in state-expended funds was $145.00.

PHC contractors include local health departments, community action programs, private non-profit organizations, Federally Qualified Health Centers (FQHCs), hospitals, and hospital districts. They provide services through clinics, provider networks, or through on-site/network combinations.

Meeting the needs of the target population is and will continue to be a challenge for PHC contractors. Increases in the number of people seeking assistance, increased costs of medical services such as pharmaceuticals and diagnostic testing, and staff recruitment and training costs drives communities to determine the most effective use of available resources to support the health care safety net 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.

- The Texas Department of Health (now known as DSHS) 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. Preventive 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 package and is the statutory authority for the Primary Health Care program administered by DSHS. The Act delineates the specific target population, eligibility, reporting and coordination elements required for program implementation. Further direction is provided in the Texas Administrative Code (TAC), Title 25 Health Services, Chapter 39 Primary Health Care Services Program.

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 crisis-oriented care.

Primary Health Care Services Description

According to TAC §39.3, because budgetary limitations exist, contractors shall focus on the provision of six priority services out of 15 primary care services defined in the Primary Health Care Services Act. 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, known as supplemental services, which 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. DSHS encourages contractors to choose the methodology that is most appropriate for their communities based upon a community assessment and available resources. Services may be provided as direct care or through a network of providers. Some possible service delivery strategies include:

On-site	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

PHC requires a community assessment and a Community Advisory Committee (CAC). These requirements were established by the enabling legislation and have remained important tools in guiding each community's program development and implementation.

Contractors must conduct 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 PHC 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 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 needs as well as an assessment of available community 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, as a result, more efficiently serve the target population.

The number of PHC-eligible clients includes those clients who met the PHC screening and eligibility requirements for income and residency and who are not eligible for other benefits providing the same services. 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 eligibility 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 appropriate referrals to other local and state programs, and education and outreach services such as health fairs and mass health risk screenings.

Fiscal Year 2004 Operations

In FY 2004, 56 PHC contractors provided services to 77,586 individuals in a 133 county service area (Table 1). These contractors had been funded since FY 2002 through a competitive Request for Proposal (RFP) process. Additional funds continued to be authorized by the Texas Legislature for FY 2004 to support the Parkland Senior Care Grant in Dallas County.

Table 1
Primary Health Care Contractors by DSHS Health Service Region
FY 2004

Region*	PHC Contractors+	Number Served	Counties Served^
Region 1	4	6,262	9
Region 2/3	11	11,355	29
Region 4/5N	11	8,485	29
Region 6/5S	3	4,724	5
Region 7	5	6,184	17
Region 8	7	12,540	11
Region 9/10	10	15,448	25
Region 11	5	7,833	8
Total	**56**	**72,831º**	**133**

*Map of DSHS Health Service Regions is included in the appendix
+PHC Contractors by description and location are included in the appendix
^ Includes counties served by Service Integration Delivery (SDI) contractors
º Total does not include number served by SDI contractors (4,755)

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
Number of Contractors by Organization Type
FY 2004

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	12
Public Health Region (Administrative Unit of DSHS)	2
Private Nonprofit Organizations	9
Total	**56**

The FY 2004 Annual Program Reports submitted by each contractor yielded information on the numbers of persons served by the program. The contractors also provided screening and eligibility services and referrals to PHC and other programs for 203,685 persons.

Medical / Non-Medical Services

Contractors report their operating costs to the program by medical service type and the number of services delivered to PHC clients (Table 3). For FY 2004, the contractors reported total expenditures for services of $14,917,327 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 693,785 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 a one-time acute illness needing immediate care.

PHC contractors also provided 310,386 non-medical services to both PHC clients as well as non-eligible clients in FY 2004 (Table 4). Some non-medical services, such as health fairs and health education classes, are not limited to PHC eligible clients and are made available to the entire community due to the setting in which they are provided and their general appropriateness for everyone.

In addition to the $14,917,327 expended for the medical and non-medical services detailed in Tables 3 and 4, contractors also reported $1,330,783 expended for administrative costs. This amount represents a reported total PHC program cost of $16,248,110 inclusive of DSHS and non-DSHS funding. PHC award dollars do not cover all expenses associated with providing care to this population, and were supplemented by at least $2,422,782 in local funding.

Table 3
Breakdown of Medical Services Provided by PHC and Average Cost Per Ser vice
FY 2004

Medical Services Type	Total PHC Expenditures	Total Number of Medical Services Provided	Average Cost Per Service to PHC
Diagnosis & Treatment	$5,805,853	203,685	$28.50
Emergency Services	45,174	398	113.50
Family Planning	55,696	1,121	49.68
Preventative Health	843,114	53,248	15.83
Health Education			
# one-to-one sessions	776,803	56,289	13.80
# group sessions	179,323	19,517	9.19
Pharmacy	1,921,682	157,175	12.23
Laboratory	1,514,506	146,617	10.33
Other Diagnostic Tests	623,453	10,901	57.19
Dental Services	345,484	10,937	31.59
SDI Contractors*	499,785	33,897	14.74
Grand Total	**$12,610,873**	**693,785**	**$18.18**

* Data management system – SDI contractors use SIEBRS (SDI Integrated Eligibility Billing and Reporting System) which 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 by PHC and Average Cost per Service
FY 2004

Service Type	Total PHC Expenditures	Total Number of Non-Medical Services Provided	Average Cost Per Service to PHC
Screening and Eligibility	$1,618,795	209,304	$7.73
Transportation	66,814	2,421	27.60
Counseling Case Management	620,845	98,661	6.29
Grand Total	**$2,306,454**	**310,386**	**$7.43**

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. This information is used in developing program goals and activities 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 objective measures the community's response to the contractor's services and is an effective tool for ongoing 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.

Impact Objectives Based On Outcome Objectives

Impact evaluation assesses the short-term effects programs have on specific behaviors in the target population. Behavioral areas that individuals can control in order to stay healthy or improve their health status 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.

For FY 2004, PHC contractors chose impact objectives based on community assessments of their target populations that identified diabetes and cardiovascular disease as the areas of most importance.

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

- sustained blood glucose control
- weight control
- exercise
- diet and nutrition
- increased 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
- decreased cholesterol
- decreased blood lipids (fats)
- weight control
- exercise
- diet and nutrition
- increased knowledge related to self-care through education and counseling

Interventions for PHC Clients in FY 2004

PHC contractors report the most frequently cited health indicators for accessing PHC funded services are diabetes, hypertension, high cholesterol and/or high lipids (fats) in the blood. These factors are the same indicators as reported in previous years.

Process Evaluation Based on Unduplicated Clients Served

All PHC contractors used the target number of unduplicated individuals to be served during FY 2004 as their primary process objective. According to data submitted on the "Performance Indicators Report Summary" for FY 2004, 20 (36%) of the contractors met or exceeded the number of unduplicated individuals they targeted to serve in their RFP response. An additional 19 (34%) achieved 80% of their estimated number to be served.

Outcome Evaluation

Outcome evaluation assesses achievement of ultimate program goals by examining changes in health status and quality of life for defined populations as evidenced by certain indicators (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.

CONTRACTOR ACCOMPLISHMENTS

Many areas of Texas have limited medical and social service resources available, which often results in a local PHC contractor being the single provider of health care services to the low-income 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 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 excerpts, organized by Health Service Region (HSR), are from annual reports submitted by PHC contractors to DSHS expressing their accomplishments during FY 2004. Despite high demand for services and limited resources, these contractors consistently make a difference in the lives of their clients.

South Plains Community Action Association, Inc. (HSR 1) serving clients in Dickens and Garza counties, provides services such as diagnosis and treatment, minor office emergency treatment, well-child exams, family planning and health education. During FY04, this contractor completed an initiative to improve health risk status by identifying and screening first-degree relatives of existing PHC clients diagnosed with diabetes mellitus. Using family trees developed by clients and PHC Service Access Managers, several first-degree relatives were notified of the availability of free diabetes screenings. Twelve of the notified family members participated in the screening that also included a health risk assessment and risk reduction education.

South Plains Public Health District (HSR 1) serving clients in Terry, Yoakum, Dawson and Gaines counties, provides acute care for adults and children, care for chronic illnesses such as hypertension, thyroid disorder and asthma, and health education programs on diabetes in conjunction with the local Texas Cooperative Extension. Incorporating the skills of a German-speaking health district employee, services are provided to a large population of Mennonites residing in Gaines County who would otherwise not have access to health care.

Abilene-Taylor County Public Health District (HSR 2) subcontracts with the Medical Care Mission Clinic to serve 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. PHC funds have served as the catalyst for the establishment of an array of services available directly from the Medical Care Mission Clinic.

Fisher County Hospital District (FCHD) (HSR 2) serves Fisher, Kent, and Nolan counties. FCHD actively pursues the development of a comprehensive and affordable healthcare system. PHC is an integral part of this development to increase the availability of affordable healthcare for uninsured and underinsured residents. The agency maintains collaborative partnerships with the YWCA, Faith in Action, the local food pantry, Texas Extension Service, local schools, churches, city and county governments. The agency's quality assurance team monitors clients with chronic diseases

such as diabetes and hypertension. The agency has a family therapist and food nutritionist on staff to counsel PHC patients free of charge. Due to the limited PHC funding, the agency provides 100 percent discounts to all PHC clients below the federal poverty level for all diagnostic testing including lab and x-ray. The agency provides a 75 percent discount to all PHC patients from 101-150 percent of the federal poverty level. The agency's pharmacy assistance program received over $750,000 in free medications for the service area residents.

JPS Health Network – Tarrant County Hospital District (HSR 3) currently provides PHC educational classes on diabetes and hypertension to 145 clients in conjunction with the Health Promotions Department at JPS Health Center Stop Six, located in a predominately African-American community in Fort Worth. Classes are held every Wednesday morning and plans are underway for evening classes. One-on-one dietician counseling, durable medical supplies, and medications are provided to clients that meet the low-income guidelines. The contractor formed a diabetes support group , with monthly meetings to provide education and encouragement and is considering offering healthy cooking classes to assist clients in improving hypertension and other health problems.

East Texas Community Health Services, Inc. (ETCHS) (HSR 4) provides primary and preventive health care services to the medically underserved residents of Nacogdoches and surrounding counties through two clinical facilities. ETCHS is the only Federally Qualified Health Center in HSR 4/5N and provides a wide array of services through direct, on-site delivery. In an effort to further improve patients' access to care, the agency recently added a second Physician Assistant to their staff and continues to provide services during non-traditional hours.

Titus County Memorial Hospital District (TCMHD) (HSR 4) provides preventive and primary care services through the Northeast Texas Rural Health Clinic and serves as a medical home to low-income and underserved residents in Titus, Morris, Camp, Franklin, and Red River counties. Specific goals and targeted activities focus on the prevention and management of diabetes, which is the most frequent diagnosis documented at the clinic. The agency works to reduce critical outcomes by increasing access to services including primary care, preventive screening, and health education. TCMHD coordinates services within the agency's health care system in order to provide a comprehensive continuum of care to residents of the service area.

Jasper-Newton County Public Health District (HSR 5N) provides comprehensive public health services from four offices in Jasper and Newton counties as well as from satellite offices in Sabine County. In addition to providing transportation services five days a week throughout rural Jasper and Newton counties, the agency also provides transportation to Lufkin, Beaumont and Galveston to ensure the underserved population has access to specialty services in these cities. The agency's targeted activity is to provide health care to underserved residents who are either at-risk for or diagnosed with cardiovascular disease, hypertension, and/or diabetes.

Williamson County and Cities Health District (HSR 7) provides primary care services to residents of Williamson County at four networked primary care clinic sites. Providers and pharmacies are assigned to the eligible target population. Services provided include preventive health care, health risk counseling, case management, and an annual physical examination. A prescription assistance program is also available. Emergency adult dental care is provided as a supplemental benefit.

Community Action of Hays, Caldwell, and Blanco Counties, Inc. (HSR 7) provides primary care services in Bastrop, Blanco, Caldwell, and Hays counties, and in a portion of Guadalupe County since 1987. The areas they serve are designated as medically underserved areas as well as health professional shortage areas. The primary focus areas for the project include access to quality health care services, diabetes, heart disease, nutrition and obesity, breast and cervical cancer, and sexually transmitted diseases. Services in these areas are provided at agency clinics and are supported by multiple funding streams.

Barrio Comprehensive Family Health Care Center, Inc. (HSR 8) located in Bexar County, serves 62 medically underserved census tracts on San Antonio's east and west sides. The agency offers medical services, family planning, prenatal services, dental services, behavioral health services, health education, and WIC. PHC funding allows the agency to focus on reducing the incidence of uncontrolled diabetes by providing health education and transportation services to clients with diabetes.

United Medical Centers (HSR 8) serves Maverick and Val Verde counties offering a comprehensive scope of services including Obstetrics, Gynecology, Internal Medicine, Pediatrics, and General/Family Medicine. Supplemental services include diagnostic lab and x-ray, WIC, family planning, podiatry, outreach, pharmacy, dental services, social services, and specialty referrals. The agency also provides onsite specialty clinics. PHC funding allows the agency to provide primary health care services with a focus on reducing the incidence of cardiovascular disease, decreasing the incidence of vaccine preventable diseases, reducing the incidence of diabetic complications, and improving the management of patient's pain.

South Texas Rural Health Services, Inc. (HSR 8) provides comprehensive primary health care at six locations in Dimmit, Frio, La Salle, and Medina Counties. The agency provides diagnosis and treatment, family planning, preventive health services, health education, laboratory services, dental services, and pharmacy services onsite. The agency provides referrals for podiatry services and social services. PHC funding allows the agency to provide quality health care to residents in rural south Texas utilizing a Diabetes Chronic Care Model.

Midland County Hospital District (HSR 9) serves clients in Midland County through a subcontract with Midland Community Healthcare Services, an FQHC since August 2004. Services offered include diagnosis and treatment, minor office procedures, preventive health for pediatrics and adult clients, and eligibility screening. Other preventive services include family planning, prenatal, and immunizations. During FY04 the agency added additional providers and increased the number of eligibility coordinators to meet client

needs. The center assists PHC clients with referrals to specialty providers and prescription needs in addition to running a cost effective Pharmaceutical Patient Assistance Program. New programs provided by the center include dental and limited mental health services.

Andrews County Health Department (HSR 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 to 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.

Lower Rio Grande Valley Community Health Management Corporation, Inc. "El Milagro Clinic" (HSR 11) provides primary health care to the medically indigent residents of Hidalgo, Cameron, Starr and Willacy counties. The services include diagnosis and treatment, preventive health care, health education, lab, X-ray and other diagnostic services, nutritional services, health screening, prescription drugs, and social services. The service delivery plan goals for this agency are to increase access to health care; reduce the incidence of diabetes and related diseases; and reduce the incidence of obesity among the target population. The Milagro Clinic is in an area of unprecedented population growth with substantial poverty (located in Hidalgo County). The counties served also have the greatest number of colonias (unincorporated settlements often lacking basic water and sewer systems, electricity, paved roads, and safe and sanitary housing) and the largest migrant population on the border with Mexico. Working closely with the City of McAllen and Hidalgo County, the agency was able to secure a permanent facility allowing it to concentrate its funding to serve the indigent target population.

Community Action Corporation of South Texas (CACST) (HSR 11) serves the rural south Texas counties of Brooks and Jim Wells, and a portion of San Patricio County. The service area is home to 175 colonias. The CACST is the principle source of primary and preventive care for the area's uninsured and low-income population since 1985. A mobile unit donated by Christus Spohn Health Systems promotes access in rural areas of the counties served. The CACST provides primary and preventive services and supplemental services such as pharmacy and health education.

SPECIAL PROJECT OVERVIEW

Parkland Health and Hospital System Senior Outreach Services (PSOS)

The Parkland Foundation, an agent for Parkland Memorial Hospital, has a geriatric program that was initiated in 1982 and has continued to expand since inception. The project was designed to provide services to senior citizens age 65 years or older residing in low-socioeconomic areas of 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.

During FY 2004, program services included:

- Case Management
- Education programs and outreach
- Senior Care Days
- Community involvement/outreach with health organizations, civic entities, and human service providers
- Van transportation
- Senior safety item distribution
- Increased outreach to faith-based organizations and Hispanic seniors

Case management services ranged from low-intensity services, such as meeting individually to determine client needs, to high-intensity services, such as special outreach efforts. A total of 267 clients received case management services. Parkland assisted in the identification of these individuals through area churches, senior centers, and other senior agencies such as Access Center for the Elderly, Senior Citizens of Greater Dallas, and City of Dallas Senior Affairs Office.

More than 20 specific outreach efforts were completed during the year including health fairs, faith-based events and "Senior Care Day," an activity that allows an organization to sponsor a senior education event, including health screenings and a brief case management assessment for participants. The van transportation service had 2,646 one-way transports for a total of 152 unduplicated clients. A program social worker developed a "Let's Talk" discussion group concept after assessing the need of many seniors to learn empowerment techniques to take charge in their lives. 94 attendees participated in three discussion groups entitled, "Let's Get Physical," "Money Matters" and "Safety in Your Home." Over 200 safety items donated by community groups and for-profit businesses were distributed to seniors. A client satisfaction survey was completed in FY 2004 with 160 surveys returned by clients. Preliminary findings include:

- Transportation and case management were most often cited as the program services of most assistance
- 51% of clients had utilized the van service
- 97% would refer a friend to the program
- 84% are satisfied with the services received

In 2004, PSOS received the National Association of Public Hospitals and Health Systems Safety Net Award for Community and Patient Service and the Community Service Award from the Dallas County Medical Association Alliance. In FY 2004, PSOS served on several local committees, one of which was the Dallas Injury Prevention Center, which assisted in the coordination and planning of a senior fall prevention seminar. PSOS continually strives to serve those who are high-risk due to low literacy, poor economic status, living alone with few support systems and that have multiple medical and/or psychosocial needs.

PRIMARY HEALTH CARE POPULATION SERVED

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 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 DSHS initiative to streamline direct health care delivery for programs, contractors and clients. This initiative 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 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 SDI contractors.

Poverty Level of PHC Clients Served in FY 2004

The majority (63%) of PHC clients served in FY 2004 live at or below 100% of the federal poverty income limits (Table 5).

Table 5
Poverty Level of PHC Clients Served
FY 2004

Percent of Poverty	Number of Clients Served	Percent
151% - 185%	387	0.5
150% - 126%	11,460	14.8
125% - 101%	13,976	18.0
100% - 76%	19,366	25.0
75% - 51%	12,973	16.7
50% - 26%	7,488	9.7
25% - 0%	9,163	11.8
Missing Data *	2,773	3.6
Total	**77,586**	**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 and Ethnicity Data

Race and ethnicity data are collected when medical services are provided. While all races are represented among the PHC program clients served (Table 6/7), the majority of clients served (66.3%) reported themselves as Hispanic. This percentage reflects a slight decrease in the reported Hispanic share of the population served at 69% in FY 2003, but still an overall increase since 57.2% in FY 2002 and 62% reported in FY 2001. PHC program staff presume that it is economic factors leading additional persons within the eligible population to seek publicly assisted health care, rather than an indication of a shift in the racial demographics of the target population.

Table 6
PHC Clients Served by Race
FY 2004

Race	Number of Clients	Percent
White	59,583	76.8
Black or African American	6,059	7.8
American Indian or Alaskan Native	132	0.2
Asian	802	1.0
Native Hawaiian or other Pacific Islander	56	0.1
Unknown	10,864	14.0
Missing	90	0.1
Total	**77,586**	**100.0**

Table 7
PHC Clients Served by Ethnicity
FY 2004

Ethnicity	Number of Clients	Percent
Hispanic	51,434	66.3
Non Hispanic	20,659	26.6
Not Available	4,755	6.1
Missing	738	1.0
Total	**77,586**	**100.0**

Educational Level and Employment Status

Information on education level and employment status is collected only from the clients aged 18 years or older who receive a medical service (Table 8). An almost 10% decrease in unemployment was reported in PHC clients aged 18 or older from 53% in FY 2003 to 44% in FY 2004. Regarding education level in FY 2004, PHC observed the majority of clients were reported as "did not specify", "unknown" and/or "missing" categories for this optional information resulting in the inability to make definite conclusions regarding the education level of PHC clients. However, for the clients that did respond, the majority have a high school diploma or its equivalency or less in educational level.

Table 8
PHC Clients Served by Education Level
FY 2004

Education Level	Percent
Clients with less than a High School Diploma	31.5
Clients a High School Diploma or equivalency	23.5
Clients with more than a High School Diploma	4.9
Clients did not specify an education level	19.4
Unknown	6.1
Missing	14.6
Total	**100**

Gender and Age

The majority of PHC clients served in FY 2004 were female (Table 9), although through the younger ages, gender was distributed evenly until puberty, when the numbers of females increased proportionately until age 65 and older.

Table 9
PHC Clients Served by Gender and Age
FY 2004

Age	Percent Male	Percent Female
Less than one year old	45.4	54.6
Ages 1 – 4	51.3	48.7
Ages 5 – 12	49.1	50.9
Ages 13 –19	34.1	65.9
Ages 20 – 64	29.3	70.7
Ages 65 and older	42.9	57.1

Please see Table A in the Appendix for summary highlights of all PHC program data from FY 1994 –2004.

Client Satisfaction Surveys

In FY 2004, PHC used a client satisfaction survey tool developed during FY 2000 to gain information on the level of satisfaction clients felt about the quality of care they received from the PHC providers (Table 10). 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 to summarize the responses quarterly.

It is optional for any client to complete a survey. Results from FY 2004 do not vary significantly from the results of the same survey tool used in FY 2003 with the exception of an increase in the number of first-time clients responding they were able to be seen within two weeks of their first call to the clinic from 68.9% in FY 2003 to 80.3% in FY 2004. Approximately 75.2% of clients completing the surveys are returning (rather than new) clients, and 62.8% have an established appointment for their visit. Of those without appointments, 76.3% report being able to be seen by a provider in the clinic on the same they arrived for a service. Approximately 94.6% either agree or strongly agree they have received high quality health care and only 29.2% report going to another provider or location for their health care needs.

The tabulated results from the entire survey are as follows:

Table 10
Client Satisfaction Survey Results
FY 2004

Survey Question	Summary Results			
Is this your first visit to the clinic?	Yes	23.8%		
	No	75.2%		
	Not Sure	1.0%		
If yes, were you seen within two weeks of your first call?	Yes	80.3%		
	No	11.1%		
	Not Sure	8.6%		
Did you have an appointment for your clinic visit today?	Yes	62.8%		
	No	35.3%		
	Not Sure	1.9%		
If you had no appt., were you seen the same day?	Yes	76.3%		
	No	15.8%		
	Not Sure	7.9%		
Do you pay any money for the services you get at this clinic?	Yes	64.5%		
	No	31.3%		
	Not Sure	4.2%		
Who is being seen at the clinic today?	Myself	69.1%	Children	3.1%
	Spouse	8.6%	Parents	1.9%
	Domestic Partner	0.5%	Friend	1.0%
	Child	14.1%	Other	1.8%
What services did this person(s) get today?	Saw the Doctor	24.7%	Cardiac Care	1.2%
	Saw the Nurse	13.6%	Routine Physical	4.5%
	Picked Up Medications	7.9%	Prenatal Services	2.6%
	Lab or Blood Work	9.0%	Intake Appointment	6.2%
	Blood Pressure Check	11.4%	Immunization/Flu Shot	2.7%
	Cholesterol Screening	3.1%	Other	6.3%
	Diabetes Check Up	6.8%		
This clinic provides me with high - quality health care.	Strongly Agree	51.5%		
	Agree	43.1%		
	Neither Agree nor Disagree	4.0%		
	Disagree	0.8%		
	Strongly Disagree	0.5%		
Does this clinic meet your medical needs?	Yes	88.2%		
	No	6.2%		
	Not Sure	6.2%		
Do you go anywhere else for your health care?	Yes	29.2%		
	No	69.2%		
	Not Sure	1.6%		

FUTURE DIRECTIONS

Health and Human Services Consolidation

With the implementation of HB 2292 from the 78th Texas Legislature, all health and human services agencies were consolidated in an effort to eliminate duplicative administrative systems and streamline processes and procedures that guide the delivery of health and human services to Texans. DSHS continues to work to ensure consistent policies, procedures and standards of care across all of the agency's Community Health Services Section programs.

Coordination with Federally Qualified Health Centers

The 79th Texas Legislature enacted Rider 58, which requires PHC grantees to coordinate the provision of services with FQHCs that are located within the same county or to examine seeking designation as an FQHC if there is no FQHC in the county. At a minimum, this coordination shall be demonstrated by the inclusion of an FQHC representative on the Community Advisory Committee for those contractors that have an FQHC in their service area. The Annual PHC-300 report has been modified in order to collect information regarding compliance with the rider.

Appendix

TABLE A Highlights of Primary Health Care Program Data for Fiscal Year 1994-2004

CATEGORY	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY04
Total clients served	98,780	100,563	109,059	107,308	87,719	85,858	89,443	85,247	85,999	91,565	77,586
Cost per client (including all types of service)	$111.72	$123.62	$118.76	$128.47	$150.19	$150.33	$178.56	$194.79	$163.99	$154.61	$145.00
Cost per Diagnosis &Treatment service only	$25.07	$24.10	$24.03	$26.54	$21.80	$21.44	$22.18	$21.17	$21.09	$25.61	$28.50
Cost per medical service	$14.04	$15.08	$14.94	$17.99	$16.80	$17.98	$26.47	$18.19	$17.39	$18.58	$18.18
Total services provided	668,363	705,682	773,359	670,915	784,060	810,298	603,339	643,069	712,764	993,173	1,004,171
No. of clients screened and referred to all programs	162,629	173,347	158,197	161,580	157,026	165,799	156,581	131,564	105,167	193,088+	209,304
No. referred to Medicaid	23,616	42,048	60,093	64,568	67,574	68,078	63,123	60,288			
No. referred to CIHCP	23,080	17,386	16,116	16,553	19,401	13,204	12,584	13,817			
Clients at or below 100% FPL	79%	77%	75%	72%	70%	73%	67%	56%	54%	59%	67%
Unemployed Clients (age adjusted)	61%	57%	54%	51%	45%	47%	48%	51%	39%	53%	44%
Percent of Clients Served:											
Less than 1 year old		1	1	1	1	1	1	2	1	0.4	0.3
Age 1 – 4		3	4	5	5	5	4	4	3	2.4	1.8
Age 5 – 12		11	12	11	12	11	10	9	7	6.6	5.0
Age 13 – 19		28	28	18	18	12	12	9	7	6.9	6.1
Age 20 – 64		51	50	59	58	65	66	69	73	76.3	78.7
Age 65 and older		6	5	6	6	6	7	7	8	7.4	8.1
Ethnicity (FY94-02):											
Hispanic	58	60	64	70	67	74	74	62	57		
White, not-Hispanic	23	21	19	18	19	17	17	15	16		
African American	17	16	15	10	11	7	8	6	5		
All other/Missing Data	2	3	2	2	3	1	1	17	22		
Race (FY03-04):											
White										78	77
African American										7	8
Asian										1	1
Other/Unknown/Missing										14	14
Ethnicity (FY03-04):											
Hispanic										69	66
Non-Hispanic										26	27
Not Available/Missing										5	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 not available or not collected

\+ SDI Contractor information not available.

TABLE B

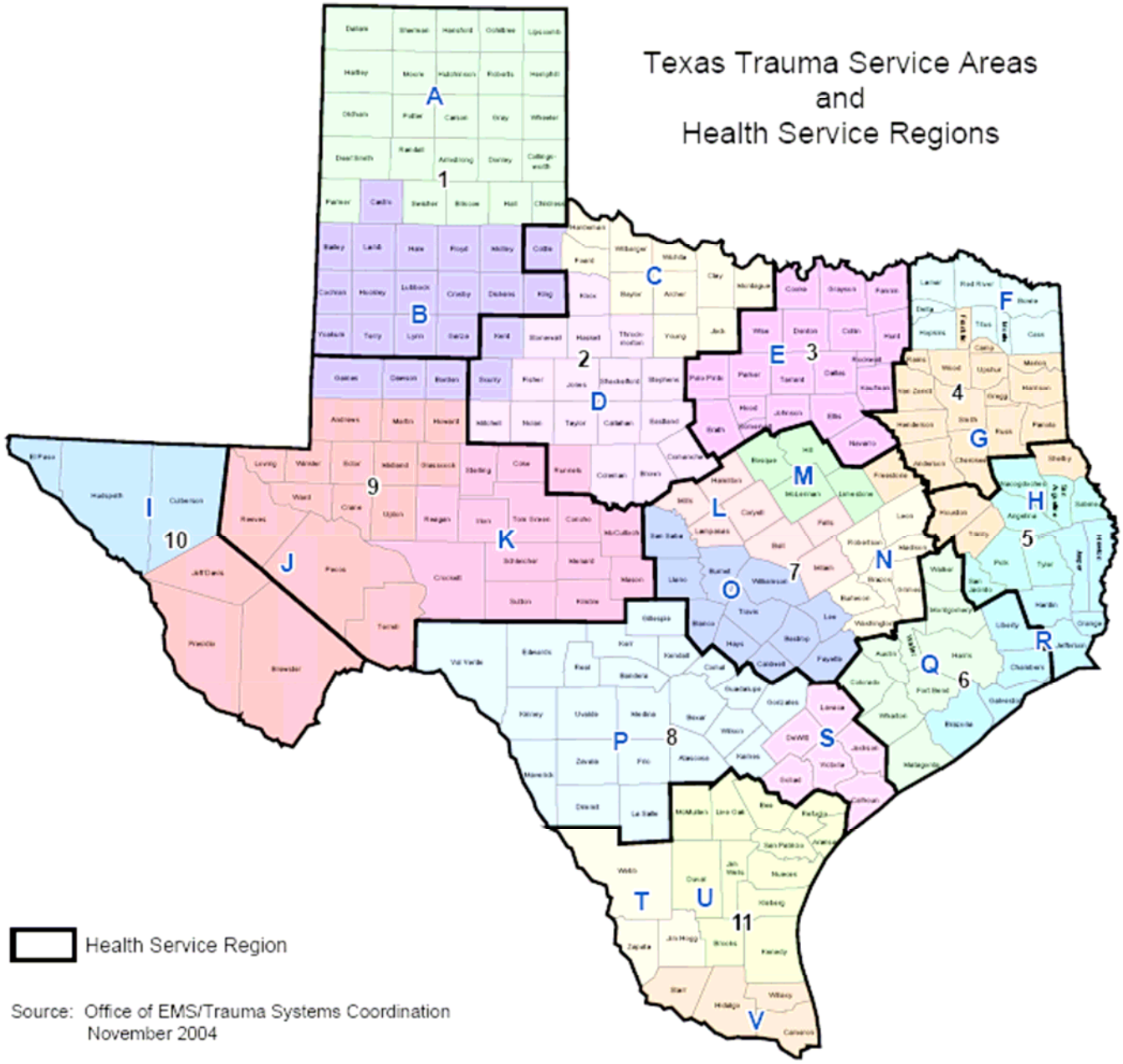
PHC CONTRACTORS FUNDING AMOUNTS, NUMBER OF CLIENTS ENROLLED, & COUNTIES SERVED FY 04					
CONTRACTORS	**ENTITY**	**YRS FUNDED BY PHC**	**INITIAL FY04 FUNDING AMT**	**# ENROLLED**	**COUNTIES SERVED**
REGION 1					
Comm Hlth Ctr of Lubbock Inc	CHC	(Since 88) 16	$ 163,356	2324	Lubbock
So Plains Comm Action Association, Inc	CAP	(Since 87) 17	209,998	521	Crosby, Dickens, Garza
So Plains Public Hlth Dist	LHD	(Since 90) 14	300,450	600	Dawson, Terry, Yoakum
So Plains Rural Hlth Services, Inc	CHC	(Since 87) 17	249,394	2817	Cochran, Dawson, Yoakum
SUB-TOTAL			**$ 923,198**	**6262**	**9 Counties**
REGIONS 2/3					
Abilene Public Health Department	LHD	(Since 93) 11	$ 226,566	1436	Taylor
Cross Timbers Health Clinic Inc	CHC	(Since 91) 13	193,754	2308	Comanche, Eastland, Hamilton
Fisher County Hospital District	HOSP	(Since 97) 7	89,352	410	Fisher, Kent, Nolan
North Central TX Comm Hlth Care Ctr	CHC	(Since 97) 7	321,302	1173	Archer, Baylor, Clay, Cottle, Foard, Hardeman, Jack, Knox, Montague, Throckmorton, Wichita, Wilbarger, Wise, Young
Shackelford Co Comm Resource Ctr	PNP	(Since 97) 7	82,514	569	Shackelford
Comm Hlth Service Agency Inc	CHC	(Since 87) 17	60,394	629	Fannin, Hunt
Corsicana Navarro Co Public Hlth Dist	LHD	(Since 90) 14	189,448	535	Navarro
Dallas Co Hosp Dist	HOSP	(Since 87) 17	257,868	1161	Dallas
Parkland Foundation	HOSP	(Since 02) 2	173,950	152	Dallas
Tarrant County Hospital Dist	HOSP	(Since 87) 17	176,818	2983	Tarrant
SUB-TOTAL			**$ 1,771,966**	**11,356**	**28 Counties**
REGIONS 4/5N					
East TX Medical Ctr - Quitman	HOSP	(Since 98) 6	$ 236,178	930	Upshur, Van Zandt, Wood
Longview Wellness Ctr, Inc	PNP	(Since 02) 2	101,038	502	Gregg
Paris-Lamar County Health Department	LHD	(Since 95) 9	151,558	843	Lamar
St. Paul Children's Foundation, Inc	PNP	(Since 99) 5	232,872	464	Cherokee, Henderson, Marion, Morris, Rains, Smith, Van Zandt
Titus Co Mem Hosp	HOSP	(Since 97) 7	94,034	448	Camp, Franklin, Morris, Red River, Titus
Angelina Co & Cities Hlth Dist	LHD	(Since 90) 14	$ 180,606	2356	Angelina

PHC CONTRACTORS FUNDING AMOUNTS, NUMBER OF CLIENTS ENROLLED, & COUNTIES SERVED FY 04					
CONTRACTORS	**ENTITY**	**YRS FUNDED BY PHC**	**INITIAL FY04 FUNDING AMT**	**# ENROLLED**	**COUNTIES SERVED**
East TX Comm Hlth Services, Inc	PNP	(Since 95) 9	$ 251,368	741	Angelina, Cherokee, Nacogdoches, Rusk, Sabine, San Augustine, Shelby
Hlthcare Extensions by Local Phys, Inc	PNP	(Since 87) 17	168,398	761	Houston, Trinity
Jasper-Newton Co Public Hlth Dist	LHD	(Since 87) 17	277,856	922	Jasper, Newton, Sabine, Taylor
Mem Medical Ctr - San Augustine	HOSP	(Since 95) 9	164,188	490	Angelina, Jasper, Nacogdoches, Newton, Panola, Sabine, San Augustine, Shelby
SUB-TOTAL			**$ 1,858,096**	**8457**	**27 Counties**
REGION 6					
Chambers-Bayside Comm Hosp	HOSP	(Since 02) 2	$ 105,248	362	Chambers
Fort Bend Family Hlth Ctr, Inc	CHC	(Since 87) 17	506,484	3556	Fort Bend, Waller
Fort Bend and Waller together		(Since 02) 2			
San Jacinto Methodist Hosp	HOSP	(Since 87) 17	277,856	812	Chambers, Harris, Liberty
SUB-TOTAL			**$ 889,588**	**4730**	**5 Counties**
REGION 7					
Brazos Valley Comm Action Agency Inc	CHC	(Since 87) 17	$ 286,850	4187	Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington
Community Action, Inc.	CHC	(Since 87) 17	193,658	347	Bastrop, Blanco, Caldwell, Hays
Llano Bay Health Care	CHC	(Since 95) 9	189,448	508	Burnet, Llano, San Saba
Williamson Co & Cities Hlth Dist	LHD	(Since 88) 16	303,116	1142	Williamson
SUB-TOTAL			**$ 973,072**	**6184**	**15 Counties**
REGION 8					
Atascosa (RHI) Health Clinic	CHC	(Since 02) 2	$ 75,778	914	Atascosa
Barrio Comp Family Hlth Care Ctr Inc	CHC	(Since 88) 16	136,910	713	Bexar
Comm Hlth Ctrs of So Central TX-Gonzales	CHC	(Since 87) 17	75,778	741	Gonzales
Community Health Development	CHC	(Since 02) 2	75,778	642	Uvalde, Zavala
El Centro Del Barrio, Inc.	CHC	(Since 97) 7	210,496	2760	Bexar
South Texas Rural Health Services	CHC	(Since 87) 17	73,388	478	Dimmit, Frio, La Salle, Medina
United Medical Centers	PNP	(Since 87) 17	473,168	6292	Maverick, Val Verde
SUB-TOTAL			**$ 1,121,296**	**12,540**	**11 Counties**

PHC CONTRACTORS FUNDING AMOUNTS, NUMBER OF CLIENTS ENROLLED, & COUNTIES SERVED FY 04					
CONTRACTORS	**ENTITY**	**YRS FUNDED BY PHC**	**INITIAL FY04 FUNDING AMT**	**# ENROLLED**	**COUNTIES SERVED**
REGIONS 9/10					
Andrews City-County Health Department	LHD	(Since 87) 16	$ 100,680	391	Andrews
La Esperanza Clinic, Inc.	CHC	(Since 88) 15	252,798	760	Coke, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Reagan, Runnels, Schleicher, Sterling, Sutton, Tom Green
Medical Ctr Hosp - Family Health Center	HOSP	(Since 95) 8	277,856	5591	Ector
Midland County Hospital District	HOSP	(Since 94) 9	473,228	2418	Midland
Pecos County Memorial Hospital	HOSP	(Since 95) 8	134,296	451	Pecos, Terrell
TDH-Region 9/10-Concho Valley Project	PHR	(Since 90) 13	184,396	451	Concho, Crockett, Kimble, Mason, McCulloch, Menard, Schleicher, Sutton
Centro De Salud Familiar La Fe Inc	CHC	(Since 96) 7	193,760	770	El Paso
Centro San Vicente	PNP	(Since 95) 8	310,836	1388	El Paso
Project VIDA	PNP	(Since 95) 8	210,496	2671	El Paso
TDH-Region 9/10-Rio Grande Project	PHR	(Since 94) 9	278,698	699	Brewster, Culberson, Hudspeth, Jeff Davis, Presidio
SUB-TOTAL			**$ 2,417,044**	**15,590**	**25 Counties**
REGION 11					
Brownsville Community Health Center	PNP	(Since 04) 4 mos.	$ 110,511	168	Cameron
City of Laredo Health Department	LHD	(Since 87) 17	138,928	543	Webb
Comm Action Corporation of So TX	CHC	(Since 87) 17	539,828	1591	Brooks, Jim Wells, San Patricio
Comm Oriented Primary Care Assoc., Inc	PNP	(Since 87) 17	110,511	0	Cameron
LRGV-Comm Hlth MGMT Corp, Inc	CHC	(Since 97) 7	378,894	1804	Cameron, Hidalgo, Starr, Willacy
Nuestra Clinica Del Valle Inc	CHC	(Since 87) 17	212,646	3484	Hidalgo
SUB-TOTAL			**$ 1,491,318**	**7590**	**8 Counties**
GRAND TOTAL (PHC)			**$ 11,445,578**	**72,709**	**127 Counties**

PHC CONTRACTORS FUNDING AMOUNTS, NUMBER OF CLIENTS ENROLLED, & COUNTIES SERVED FY 04					
CONTRACTORS	**ENTITY**	**YRS FUNDED BY PHC**	**INITIAL FY04 FUNDING AMT**	**# ENROLLED**	**COUNTIES SERVED**
Denton Co Health Department (SDI)	LHD		$ 185,392	1948	Denton
Smith Co Public Health District (SDI)	LHD		124,020	4152	Anderson, Cherokee, Dallas, Gregg, Henderson, Kaufman, Rains, Rockwall, Rusk, Smith, Titus, Upshur, Van Zandt, Wood
Fayette Memorial Hospital (SDI)	HOSP		130,964	870	Fayette, Lee
SUB-TOTAL			**$ 440,376**	**6970**	**6 Additional Counties Statewide**
GRAND TOTAL WITH SDI			**$ 11,885,954**	**79,679**	**133 Total Counties Served**
PROVIDER CODES		# CONTRACTORS			
Community Action Program	CAP	3			
Community Health Center	CHC	19			
Hospitals/Hospital District	HOSP	11			
City and/or Co Health Dept	LHD	9			
Health Service Region (DSHS)	HSR	2			
Private Nonprofit Organization	PNP	9			
Total Contracts		**53**			
SDI PROVIDER CODES					
Hospitals/Hospital District	HOSP	1			
City and/or Co Health Dept	LHD	2			
Total Contracts for SDI		**3**			
TOTAL ALL CONTRACTS		**56**			

CHC – Community Health Center **CAP** – Community Action Program **LHD** – Local Health Department **HOSP** – Hospital or Hospital District
PNP – Private Non-Profit Organization **PHR** – Public Health Region


Texas Trauma Service Areas
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Health Service Region
Source: Office of EMS/Trauma Systems Coordination
November 2004

Percent of Poverty Income Levels for 2004

In accordance with 25 TAC Rule §1.91, the department follows a standardized procedure for developing, distributing and implementing percent of poverty income guidelines based on U.S. Poverty Income Guidelines issued by the Secretary of HHS and published each year in the Federal Register. The table below shows the 2004 Percent of Poverty Income Levels, from 2004 Guidelines published February 13, 2004.

Family Size	Annual										Monthly									
	21%	25%	50%	100%	133%	150%	185%	200%	250%	300%	21%	25%	50%	100%	133%	150%	185%	200%	250%	300%
1	$1,955	$2,328	$4,655	$9,310	$12,382	$13,965	$17,224	$18,620	$23,275	$27,930	$163	$194	$388	$776	$1,032	$1,164	$1,435	$1,552	$1,940	$2,328
2	$2,623	$3,123	$6,245	$12,490	$16,612	$18,735	$23,107	$24,980	$31,225	$37,470	$219	$260	$520	$1,041	$1,384	$1,561	$1,926	$2,082	$2,602	$3,123
3	$3,291	$3,918	$7,835	$15,670	$20,841	$23,505	$28,990	$31,340	$39,175	$47,010	$274	$326	$653	$1,306	$1,737	$1,959	$2,416	$2,612	$3,265	$3,918
4	$3,959	$4,713	$9,425	$18,850	$25,071	$28,275	$34,873	$37,700	$47,125	$56,550	$330	$393	$785	$1,571	$2,089	$2,356	$2,906	$3,142	$3,927	$4,713
5	$4,626	$5,508	$11,015	$22,030	$29,300	$33,045	$40,756	$44,060	$55,075	$66,090	$386	$459	$918	$1,836	$2,442	$2,754	$3,396	$3,672	$4,590	$5,508
6	$5,294	$6,303	$12,605	$25,210	$33,529	$37,815	$46,639	$50,420	$63,025	$75,630	$441	$525	$1,050	$2,101	$2,794	$3,151	$3,887	$4,202	$5,252	$6,303
7	$5,962	$7,098	$14,195	$28,390	$37,759	$42,585	$52,522	$56,780	$70,975	$85,170	$497	$591	$1,183	$2,366	$3,147	$3,549	$4,377	$4,732	$5,915	$7,098
8	$6,630	$7,893	$15,785	$31,570	$41,988	$47,355	$58,405	$63,140	$78,925	$94,710	$552	$658	$1,315	$2,631	$3,499	$3,946	$4,867	$5,262	$6,577	$7,893
9	$7,298	$8,688	$17,375	$34,750	$46,218	$52,125	$64,288	$69,500	$86,875	$104,250	$608	$724	$1,448	$2,896	$3,851	$4,344	$5,357	$5,792	$7,240	$8,688
10	$7,965	$9,483	$18,965	$37,930	$50,447	$56,895	$70,171	$75,860	$94,825	$113,790	$664	$790	$1,580	$3,161	$4,204	$4,741	$5,848	$6,322	$7,902	$9,483
11	$8,633	$10,278	$20,555	$41,110	$54,676	$61,665	$76,054	$82,220	$102,775	$123,330	$719	$856	$1,713	$3,426	$4,556	$5,139	$6,338	$6,852	$8,565	$10,278
12	$9,301	$11,073	$22,145	$44,290	$58,906	$66,435	$81,937	$88,580	$110,725	$132,870	$775	$923	$1,845	$3,691	$4,909	$5,536	$6,828	$7,382	$9,227	$11,073
13	$9,969	$11,868	$23,735	$47,470	$63,135	$71,205	$87,820	$94,940	$118,675	$142,410	$831	$989	$1,978	$3,956	$5,261	$5,934	$7,318	$7,912	$9,890	$11,868
14	$10,637	$12,663	$25,325	$50,650	$67,365	$75,975	$93,703	$101,300	$126,625	$151,950	$886	$1,055	$2,110	$4,221	$5,614	$6,331	$7,809	$8,442	$10,552	$12,663
15	$11,304	$13,458	$26,915	$53,830	$71,594	$80,745	$99,586	$107,660	$134,575	$161,490	$942	$1,121	$2,243	$4,486	$5,966	$6,729	$8,299	$8,972	$11,215	$13,458
For each Additional Member Add:	$668	$795	$1,590	$3,180	$4,229	$4,770	$5,883	$6,360	$7,950	$9,540	$56	$66	$133	$265	$352	$398	$490	$530	$663	$795

Source: "Annual Update of the HHS Poverty Guidelines," Department of Health and Human Services, *Federal Register*, Vol. 69, No. 30, February 13, 2004, pp. 7335-7338.

Prepared by: TDH-AFH, BSS-R&PHA, February 2004. Effective April 1, 2004.