TEXAS DEPARTMENT OF HEALTH

PRIMARY HEALTH CARE
PROGRAM
FISCAL YEAR 2001

Annual Report

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

PHC program goals are to:

- Build and stabilize local provider capacity;
- Catalyze the local health and human services systems; and
- Increase the availability and accessibility of primary health care services to the medically indigent population of Texas.

In FY2001, the PHC program distributed $13,701,331 in state-allocated funds to 54 contractors across the state. Every public health region had from four to ten contractors. Services were provided in 115 counties and 85,247 unduplicated clients received primary health care services ranging from attending a class about reducing cholesterol, to visiting a health care provider for an acute infection or a chronic condition Costs for medical services, excluding administrative costs, totaled $11,697,422. A total of 643,069 medical services were provided. The average cost per PHC client for medical services was $194.79 and the average cost per medical service was $18.19.

PHC contractors are local health departments, community health centers, private non-profit organizations, hospitals and hospital districts, government entities and university residency programs. They provide their services in a variety of ways, be it direct services via a clinic, or through a network of providers, or through community outreach.

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 contractor. 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 holds opportunities for new assistance avenues for the medically needy population, further economic downturns will impact the demand for publicly funded medical assistance. 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 resources most effectively to meet their unmet needs.

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. This decrease created a group of people referred to as the medically indigent. 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 is 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 PHC.

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.

FY01 Statistics

In FY01, the 16th year of the program, 85,247 unduplicated clients were served with appropriated funding totaling $13,701,331. This funded 54 contractors serving 115 counties (Table 1). A more detailed version of this table can be found in the appendix. The level of funding has remained constant since FY94. In FY01, contractors were funded through a continuation Request for Proposal (RFP) process, meaning that only current contractors were able to submit proposals.

Primary Health Care Regional Break Down
Table 1

Region*	PHC Contractors+	Dollar Amount	Number Served	Counties Served
1	5	$1,111,449	6,258	9
2/3	10	$2,254,291	11,981	28
4/5	10	$2,412,032	10,499	23
6/5	4	$1,078,883	3,419	6
7	5	$1,198,580	5,206	15
8	5	$1,129,027	17,929	8
9/10	10	$2,757,665	18,152	20
11	5	$1,759,404	11,803	6
Total	**54**	**$13,701,331**	**85,247**	**115**

*Map of the TDH regions included in the appendix
+PHC Contractors by description and location included in the appendix

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

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

The remaining nine services that may also be provided are:

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

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

Contractors by Type
Table 2

Type of Program for PHC	Number of Contractors
Community Action Program	4
Community Health Center	13
Hospitals/Hospital District	10
City and/or County Health Dept.	12
Public Health Region (Administrative Unit of TDH)	2
Private Nonprofit Organization	11
University Residency Program	1
Governmental Entity	1
Total	**54**

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 the local community assessment and available resources. 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.

Program Hallmarks
Hallmarks of the PHC program include the mandatory screening with the Texas Eligibility Screening System (TESS), required community assessment and the Community Advisory Committee (CAC).

The Health and Human Services Commission in 1994 developed TESS. This screening allows all family members to be screened at one time for more than 40 health and human service agency programs. While TESS is not an eligibility program and does not ensure eligibility, it does provide comprehensive referral information so that the entire family may be directed to the services most appropriate for them.

Communities use a community assessment in planning and implementing pertinent services to the target population. and in meeting the community's needs. Contractors are encouraged to seek technical assistance from the PHC program staff or other sources regarding community assessment as well as to work with other entities within their communities. This comprehensive approach helps 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. 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. 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 and design specific interventions to address these issues.

PRIMARY HEALTH CARE CLIENTS

Primary Health Care (PHC) clients represent all races, ethnicities, genders and age groups. They are often referred to as the medically indigent or the working poor. The socio-economic status of PHC clients cover a wide range as well, since the PHC program provides benefits to people in Texas who have a family income at or below 150% of the Federal Poverty Income Guidelines. PHC clients live in every region of the state. Some are employed. Some are not. Most of them did not receive regular medical care before qualifying for the PHC program. Prior to becoming eligible for PHC, many of clients received their medical care from hospital emergency rooms, where services cannot be denied due to an inability to pay.

The PHC program annual estimates its target population within the state by taking the number of Texans who have incomes at or below 150% of the Federal Poverty Income Guidelines, and subtracting those Texans within that income category who 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 3 shows, the number of individuals potentially eligible to receive PHC services is 2,053,772. In FY01, PHC contractors served 85,247 clients, or 4.15% of the target population.

Target Population of the PHC Program – FY01

Table 3

Estimated number of persons in Texas at or below 150% of poverty[1]	6,359,805
Estimated number of Texans below 150% of poverty with employer group insurance or other private insurance, excluding Medicaid and Medicare[2]	1,730,868
Average monthly enrollment in Medicaid (all programs)[3]	1,788,168
Estimated number of Texans below 150% of poverty with only Medicare coverage[4]	749,168
Estimated number of individuals in FY 01 enrolled in the County Indigent Health Care Program (CIHCP)[5]	37,829
Estimated target population of the Primary Health Care Program	2,053,772

[1]Texas A&M University, Texas State Data Center, 2000 Population Estimates, 8/98. U. S. Bureau of the Census, STF-4 from 1990 Census.
[2]U. S. Bureau of the Census, Current Population Reports, Health Insurance Coverage: 1999, 9/2000.
[3]Texas Department of Health, Health Care Financing, Bureau of Statistics and Analysis, Medicaid Enrollment Reports for FY 2000.
[4]U. S. Department of Health and Human Services, Health Care Finance Administration, Medicare Enrollment Data for 1999. Data for 2000 not yet available.
[5]Texas Department of Health, County Indigent Health Care Program, FY 2001.

Demographics
The overwhelming majority (55.8%) of PHC clients served in FY 01 live at or below 100% of the federal poverty income limits (Table 4). Of these, 25.2% were between 76% and 100% of poverty. This means there was at least some income in the household.

Poverty Level of PHC Clients Served in FY 01
Table 4

Percent of poverty	Number of Clients Served	Percentage
150% - 126%	11,855	13.9
125% - 101%	11,533	13.5
100% - 76%	21,477	25.2
75% - 51%	10,655	12.5
50% - 26%	6,153	7.2
25% - 0%	9,215	10.9
Missing Data*	14,359	16.8
Total	**85,247**	**100.0**

* Missing data due to contractor data management problems

Race
All races are represented among the PHC program clients (Table 5) with the majority being Hispanic.

PHC Clients Served in FY01 by Race
Table 5

Race	Number of Clients	Percentage
Hispanic	53,082	62.3
White, Non-Hispanic	12,459	14.6
African American	5,222	6.1
Asian	308	0.4
Native American	40	0.0
Not Specified	842	1.0
Missing Data*	13,294	15.6
Total	**85,247**	**100.0**

* Missing data due to contractor data management problems

Education Level
Half of the clients have less than a high school diploma (Table 6).

PHC Clients Served in FY01 by Education Level
Table 6

Education Level	Percentage
Clients with less than a high school diploma	50.0
Clients with a high school diploma or equivalency	26.0
Clients had more than a high school diploma	7.0
Clients did not specify an education level	17.0
Total	**100.0**

Gender and Age
The majority of PHC clients served in FY 01 was female (Table 7). Slightly less than half of PHC clients aged 18 or older were also unemployed (51%), and slightly more than half were married (53%). Data on education, marital, and employment status are

collected only on those PHC clients over age 18. See Table A in the Appendix for summary highlights of PHC program data from FY 91 - 01.

Gender by Age of PHC Clients Served in FY 01
Table 7

Age	Percent Male	Percent Female
Less than 1 year	43.0	57.0
Ages 1-4 years	46.0	54.0
Ages 5-12 years	43.0	57.0
Ages 13-19 years	41.0	59.0
Ages 20-64 years	30.0	70.0
Ages 65 and older	37.0	63.0

Client Satisfaction

In FY 01, the PHC program used a client satisfaction survey developed during FY 00 to gain information regarding the level of satisfaction clients felt regarding the quality of care they were receiving from their providers. Depending on the client's preference, surveys are provided by the contractor in either English or Spanish.

Contractors were required to collect a minimum of 10 surveys per month and were directed to summarize the responses quarterly. The results from the survey are as follows:

FY 01 Client Satisfaction Survey Results
Table 8

Survey Question	Summary Results	
Is this your first visit to the clinic? If yes, were you seen within two weeks of your first call?	21% yes 78% no 1% not sure 81% yes 11% no 8% not sure	
Did you have an appointment for your clinic visit today? If you had no appointment, were you seen in the clinic the same day?	66% yes 33% no 1% not sure 73% yes 21% no 6% not sure	
Do you pay any money for the services you get at this clinic?	61% yes 36% no 3% not sure	
Who is being seen at the clinic today?	70% myself 6% spouse 0% domestic partner 14% child (1)	4% children 2% parent(s) 1% friend 3% other
What services did this person(s) get today?	25% saw the doctor 16% saw the nurse 7% picked up medications 7% lab work or blood work 13% blood pressure check 3% cholesterol screening 6% diabetes check-up	2% cardiac care (heart) 5% routine physical 2% pre-natal services 5% intake appointment 4% immunization/flu shot 5% other
This clinic provides me with high quality health care	53% strongly agree 42% agree 3% don't agree or disagree	1% disagree 1% strongly disagree
Does this clinic meet your medical needs?	89% yes 8% no 3% not sure	
Do you go anywhere else for your health care?	31% yes 68% no 1% not sure	

PRIMARY HEALTH CARE CONTRACTORS

Services

In FY 01, 54 PHC contractors provided services to 85,247 individuals in a 115 county service area. Approximately two thirds of these counties are designated as rural and the rest are designated as urban.[1]

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 following private and public entities provided PHC services to eligible individuals in FY 01:

- Community Action Programs (4)
- Community Health Centers (13)
- Hospitals/Hospital Districts (10)
- City and/or County Health Departments (12)
- Public Health Region Administrative Units of Texas Department of Health (2)
- Private Nonprofit Organizations (11)
- University Residency Programs (1)
- Governmental Entity (1)

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

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

FY01 Annual Program Reports yielded the following the tables that summarize the number of clients served (Table 9) and the costs associated with both the medical (Table

[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.

10) and non-medical services (Table 11) provided by PHC contractors and/or their subcontractors.

Medical Services Costs

Contractors reported their operating costs to the program by medical service type and represented the number of services delivered to the PHC clients (Table 10). This information is summarized to reflect the average costs of service 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.

PHC contractors also provided 292,432 non-medical services to both PHC-eligible clients as well as non-eligible clients in FY 01 (See Table 11). Some non-medical services, such as health fairs and health education classes, are not limited to PHC eligible clients but are made available to the entire community due to the setting in which they are provided and their general appropriateness for everyone.

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

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

Clients Served in FY01
Table 9

PHC Eligible clients served	85,247 Unduplicated eligible clients
One-Time Basis clients served	15,451 Unduplicated clients
Total number of individuals screened and referred to other programs: Of these:	131,564 60,288 were referred to Medicaid 13,817 were referred to CIHCP
Total number of outreach services: Of these:	91,597 53,580 people attended Health Education Classes 38,017 Hotline calls

Breakdown of Medical Services Provided and Costs Charged to the PHC Grant in FY 01

Table 10

Medical Service Type	Total PHC Dollars Spent	Total Number of Medical Services Provided	Average Cost Per Service to PHC
Diagnosis & Treatment	$4,389,243	207,344	$21.17
Emergency Services	$23,634	208	$113.62
Family Planning	$56,203	1,308	$42.97
Preventive Health	$1,010,360	58,190	$17.36
Health Education (one-on-one)	$752,165	53,580	$14.04
----X-rays	$428,520	6,654	$64.40
----Pharmacy	$3,232,430	167,218	$19.33
----Laboratory	$1,098,400	102,431	$10.72
----Other Diagnostic Tests	$173,623	3,967	$43.77
Dental Services	$124,957	4,880	$25.61
Medical Referrals	$312,764	19,560	$15.99
Other Medical Services	$95,123	17,729	$5.37
Grand Total	$11,697,422	643,069	$18.19

Breakdown of Non-Medical Services Provided and Costs Charged to the PHC Grant in FY 01
Table 11

Service Type	Total PHC Dollars Spent	Total Number of Non-Medical Services Provided	Average Cost per Service
Screening and Eligibility	$1,874,113	147,583	$12.70
Transportation	$75,710	4,582	$16.52
Other Non-medical Services	$699,034	140,267	$4.98
Grand Total	$2,648,857	292,432	$9.06

It may be observed that the charges ($14,346,279) for both medical and non-medical services for PHC clients totaled more than the amount appropriated. PHC contractors often find that to meet their PHC clients' needs, they must seek additional funding sources that enable them to provide services beyond the funding levels provided through their contract with TDH.

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

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

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

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

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

Process Evaluation
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 01 as their primary process objective. According to data submitted on the "Performance Indicators Report Summary" for FY 01, 35% of the contractors met or exceeded the number of unduplicated individuals they targeted to serve.

Impact Objectives Based On Outcome Objectives
Impact evaluation assesses the short-term effects programs have on specific behaviors in the target population. Behaviors that individuals control in varying degrees in order to take an active part in becoming healthier include, but are not limited to: nutrition, exercise, tobacco use, alcohol consumption, sexual activity, and increased knowledge and skill in other areas of self-care.

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

- 66% of the PHC contractors identified diabetes
- 32% of the PHC contractors identified cardiovascular disease

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

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

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

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

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

Ninety two percent (92%) of those met were related to diabetes management. The other eight percent were related to the management of cardiovascular disease. This probably 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. Table 7 indicates that 30% of PHC Program visits were for the management of diabetes, while 27% related to hypertension as an indicator of cardiovascular disease.

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 01

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

A total of 643,069 medical services were provided. The most frequent service includes preventive and primary care through the provision of client education/ counseling, prenatal (pregnancy) care, well-child exams, immunizations, gynecological exams with/without contraceptive management, and adult baseline or periodic physical exams.

PROGRAM ACCOMPLISHMENTS

Many areas of Texas have limited medical and social resources available, which often result in a local Primary Health Care (PHC) contractor being the only provider of health care services 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 impact of their care on the medical resources of the local community. PHC contractors and clients were challenged by continued limitations of level funding from FY2000, and health industry issues regarding recruitment, training and retention of qualified healthcare providers in a competitive market. PHC contractors developed innovative strategies utilizing PHC funding to cope with the unmet needs of their communities, but consistently reported continued and growing demands for more services for the populations served. The following materials are excerpts from contractor Annual Reports to the Texas Department of Health expressing their achievements, limitations and proposed future directions for their communities.

Community Health Center of Lubbock (PHR 1) located in urban Lubbock and its surrounding rural areas, provides a comprehensive service array to include primary, acute, chronic and preventive care to individuals at various life stages. The incidence of diabetes in this area has escalated in recent years, and to meet that need, one of the center's main focuses has been to improve the delivery of care to the diabetic population. Their services include diabetic education, case management, podiatry, nephrology, ophthalmology and dental care.

Andrews County Health Department (PHR 9) of Andrews provides comprehensive primary health care and public health services for those clients unable to provide for their care with insurance or personal funds or through utilization of the emergency room of the local public hospital. They have coordinated state and county funding resources to provide tubal ligations for PHC clients; increasing clinic schedule times for diabetic and hypertensive clients needing education and service plan review; implementing diabetic and hypertension minimum standards; conducting microalbuminuria testing at the clinic; and continuing the worksite wellness program and participation in a health fair to attract new clients. The county has also assisted in provided the additional funds in FY2001 to remodel the clinic to improve client privacy, improve adherence to infection control standards, and refurbishing the public areas of the clinic. The agency continues to face challenges in providing dental care for clients over age 21; analyzing community health problems; maintaining proper blood sugar levels in the diabetic population; educating clients in regards to their medications; and addressing staffing challenges in a remote rural area.

Centro San Vicente (PHR 10) of El Paso is a participant with over thirty social service agencies known as Community Voices of El Paso. This organization has received one of twenty-three HRSA Community Access Program Grants to develop a Community Call Center to serve as a medical nurse hotline and information broker for linkages to health care services within the community. This mechanism provides an opportunity to enroll clients in assistance programs and also assists in the establishment of a "medical home" providing social and medical case management. Future plans include development of health insurance for employers/employees currently unable to finance their health insurance needs.

Concho Valley Project (PHR 9) provided by the Public Health Region 9/10 of San Angelo coordinates a network of 14 clinics with 26 medical providers and 12 pharmacies to serve an eight-county rural service area. The project provides prevention, primary care and pharmaceutical services, but faces challenges in providing the unmet needs for specialty care and additional diagnostic testing due to funding and staffing constraints. Pharmaceutical services for FY2001 averaged five prescriptions for each patient served.

Fisher County Hospital District (PHR 2) located in Rotan has established a local network of federal, state, county and city government and social services agencies to develop a comprehensive rural healthcare system in a regional area identified as a Health Provider Shortage, Medically Underserved and Frontier Area. They have expanded their pharmacy assistance program to provide $280,000 of assistance in Fisher County and further expanded to include Kent County for both the Title V Maternal and Child Health and PHC programs in FY2001. Quality Assurance Improvement activities have incorporated quality assurance indicators, measures, monitoring tools and plans to develop baseline measures for coming years. Future plans are to seek designation as a Federal Qualified Health Center for the Roby facility.

North Central Texas Community Healthcare Center, Inc. (PHR 2) serving clients in 10 counties including the Wichita Falls urban area, has expanded facilities and operations to encompass further developments in the patient base for dental services; establishment of diagnostic imaging and incorporation of social services supports in their new facility to provide more preventive and extended or specialty care with PHC funds. This increases the integrated base of services available within the community and supports the needs of the community's clients with a central location and staff. Future plans are to further develop referral relationships with providers in the Dallas/Fort Worth metroplex area.

Parkland Health and Hospital System (PHR 3) located in Dallas operating nine community health centers, 10 Youth and Family Centers, in traditionally underserved areas of the city. The East Dallas Clinic has begun an open access program, which facilitates same day appointments for acute care with over half of the daily appointments available for open access scheduling. This program has resulted in reduction of no-show rates as appointment show rates increased from 62-66% to 85-93% as sees all acute care patients on the same day and all other appointments within two weeks.

Titus County Memorial Hospital District (PHR 4) in Winfield, serving the Titus and four surrounding medically underserved counties, provides care to all with limited resources available to commit to prevention and education. The hospital operates the Northeast Texas Rural Health Clinic and has provided a medical home to uninsured and underinsured patients, offering these patients an alternative to the emergency room and an opportunity to prevent and manage chronic health care problems. The agency continues to be challenged with choices of expanding the enrolled client base or continuing to provide the comprehensive screenings and preventive care mandated by PHC to currently enrolled clients. The project has concentrated on ensuring all enrolled clients receive the services prescribed by the program, which has slowed the growth of the project. PHC funding has been used to provide home glucose monitors and strips to PHC clients as well as medication assistance, has resulted in a greater incidence of sustained blood sugar control among clients.

Healthcare Extensions by Local Physicians (HELP) (PHR 5) of Crockett provides a network model of physicians serving primary care needs to needy and qualified persons in Houston and Trinity Counties. The organization is co-located with regional health department operations of TDH which helps facilitate the outreach, assessment, education and referral functions of HELP. The agency is not a clinical setting, but provides an access to primary care and referral services to eligible persons in an underserved rural community where resources are very limited. PHC funds were utilized to provide ongoing primary care to low-income and/or uninsured clients in the area with appropriate referrals to hospital indigent/charity programs for patients requiring in-patient treatment, extensive testing and/or specialty care.

Brazos Valley Community Action Association (BVCAA) (PHR 7) of Bryan serves residents in Brazos County, which includes both urban and rural locations. Their Community Health Clinic Project is the result of a collaborative effort of BVCAA, Texas A&M University, City of Bryan, City of College Station, Episcopal Health Charities as well as other foundations and community donors. BVCAA has established the Community Health Clinic project to provide clients with a single facility where most of their preventive and primary care needs can be met. PHC funds enabled their Family Health Clinic to provide physician-based outpatient preventive and primary care and coordinate linkages with case management providers, local and regional hospitals, and health care and social services providers, as on-site visits or through arrangement with the TAMU Family Residency Program.

Fort Bend Family Health Center (PHR 6) of Richmond near the Houston metropolitan area is a federally qualified health center look-alike developed through coordination of various public and private agencies to assist the relatively small low-income population. It is the sole source of low-cost health care the medically underserved population in Fort Bend County. PHC funds have been used to staff a pharmacy which provides services only client population served within the Family Health Center; fund a chronic care model for diabetes patients which has resulted in a decline of HgAlc from 11 to 8.8 in one year; and provide for purchase of a mobile clinic van to make trips two to three times per week to outlying rural areas of Fort Bend and Waller Counties. Future plans are to further

develop the use of the chronic care model with cardiovascular patients beginning with the diabetic dual diagnosis patients.

Barrio Comprehensive Family Health Care Center, Inc., (PHR 8) of San Antonio and serving Bexar County residents, focuses their PHC efforts on complications of diabetes management, cardiovascular disease associated with hypertension, cardiovascular disease associated with hyperlipidemias, and obesity in the community by providing health education in a variety of forums and venues. They have developed a referral tracking system to provide monitoring and follow-up on those clients referred for health education or other services. Such feedback provides the physician with valuable information to evaluate a patient's compliance with advice

El Centro del Barrio (PHR 8) also of San Antonio and the surrounding Bexar County area, utilizes PHC funds to maintain linkages and cooperative with other health and human service providers to meet local needs. They have been able to extend access to preventive and primary medical, dental and social services care to many of the community's most vulnerable and high-risk populations, including the homeless, battered women, abused and/or neglected children, persons living with HIV/AIDS, teens in a high school with high pregnancy rates, and rural residents with limited access to primary care. This organization provides access for medical and dental care through extended evening and weekend hours for urgent primary care and their clinics are often co-located in places frequented by the client population, such as homeless shelters or a high school. Diabetes and Cardiovascular Disease/ Hypertension management are addressed with pharmacy assistance to support prescribed medication regimens for complex medical conditions. In FY2001, they have opened a new clinic with care services available to 9 p.m. weekdays, created a dermatology specialty care clinic via telemedicine link with University Health System, expansion of the OB-GYN clinic and implementation of an asthma self-management initiative.

United Medical Centers (PHR 8) of Eagle Pass serving persons in Maverick and Val Verde Counties on the Texas-Mexico border with a comprehensive service delivery plan to establish a "health home" for their clients. They utilize PHC funds to provide staffing costs for the evening clinic to enhance continuity of care for patients, particularly those with diabetic and hypertensive conditions. Their goals are to decrease the incidence of cardiovascular disease, vaccine preventable diseases, and reduce diabetic complications by providing preventive care, education and diagnostic testing within their medically underserved largely bilingual and bicultural community. The agency sponsors a Recruitment and Retention Program featuring a rural clinical rotation opportunity for health professions students and teleconferencing facilities and equipment to support learning and clinical activities in the community and surrounding counties.

Nuestra Clinica Del Valle (PHR 11) of Pharr serving the population in Hidalgo and Starr Counties with services focusing on Cardiovascular Disease, Diabetes Mellitus

among adults age forty and older, and vaccine preventable disease among clients age sixty and older. They utilized PHC funding to complete risk assessments for hypertension and provide patient counseling and education regarding risk factors related to these conditions. The agency surpassed their goal in the number of unduplicated clients by over two thousand additional clients than projected.

SPECIAL PROJECT OVERVIEW

St. Paul Healthcare Outreach Initiative

Background
The Smith County Public Health District partners with the St. Paul Foundation on children's issues. 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. The community raised funds, a structure was built, and the operation was put under the direction of the Health District with St. Paul as an unpaid "landlord." It is a partnership that has a significant impact on the community with its full-time physician, three nurses, 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. It was approved and a two-year contract was issued to fund the design development, purchase the van and equipment required, recruit and train staff and determine roles and responsibilities.

Process
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.

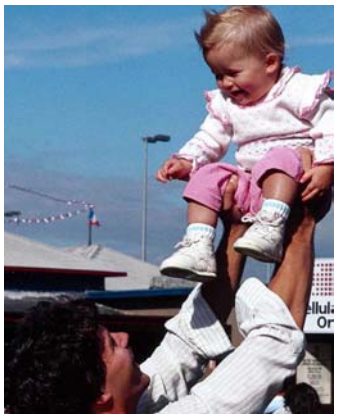
The mobile unit was designed as a transport vehicle to move supplies, equipment and staff to an outlying clinic site. Minimal fixed equipment such as examination tables and scales, were purchased for each site. A local community coordinator would ensure the site was ready for a scheduled clinic operation, and that appropriate patients had booked appointments.

Overview of St. Paul Healthcare Outreach Primary Care Patients
Most of the patients seen have no insurance, and have not seen a physician in two to 20 years. They present with numerous health problems and many have social/psychiatric problems and exhibit unhealthy lifestyle choices. Most patients require a complete history and physical to assess varying symptom complaints. These patients require extensive appointment times to address these needs and the increased need for patient education.

Outcome
The mobile van unit, the mobile staff and the services provided are well received in the communities affected. The coordination of this effort between the counties served, the partners involved and the activities undertaken have resulted in strong performance and acceptance of the service and its delivery methodology. It makes a difference in access to care and serves to increase the public health safety net.

During the FY 01 operating year, the program reports providing 1,620 pediatric immunizations, 232 adult immunizations, 707 primary care visits to children and adults, and making 61 referrals to specialists as well as 14 referrals to emergency rooms for immediate care. This program has identified significantly more individuals with major medical conditions or health risks and has intervened with health education/motivation for the clients as well as providing basic health care. In late October 2001 the Texas Rural Health Association presented a "Communities That Care – 2001" Award to the St. Paul Healthcare Outreach Initiative.

THE FUTURE



The need for primary health care services continues to grow, particularly as economic downturn trends filter through all levels of the marketplace. The Primary Health Care (PHC) Program will continue to provide a health care access safety net for Texans without other means of accessing health care, unmet demand and need may not be addressed with additional funding resources.

During the foreseeable future, a number of developments will impact the way that the PHC Program provides services to its clients. These developments include additional health care programs, which may impact the current mix of clients receiving PHC services although numbers of eligible clients in need are expected to rise, self-developed performance measures will generate more selective and focused programming to met stated objectives, and the possibility of a revised funding grant strategy for PHC funds in future periods.

Changes in Health Care Delivery

New developments in health care delivery may have implications for the PHC program. These are the Service Delivery Integration (SDI) initiative, the Children's Health Insurance Program (CHIP), and the Title XIX Medicaid Expansion Waiver Application. SDI is designed to integrate the services and administration of the Primary Health Care Program, Title XX (Family Planning), and Title V (Maternal and Child Health, Genetics, Children with Special Health Care Needs, and Dental). Three PHC contractors have volunteered to participate in SDI.

CHIP is a program designed to provide health care insurance to children of families that meet the program eligibility requirements. Some of these eligibility requirements overlap with the PHC Program and this will require answers to questions concerning families who are eligible for and use both programs. An example of such questions deals with the effects of varying co-pays between the two programs, among other administrative overlaps.

The Women's Health Waiver is an effort led by the Health and Human Services Commission (HHSC) to expand Medicaid coverage to 185% of FPIL for women age 18 to 44 in Texas. The waiver includes coverage for 1) family planning services and preventive health screening services, and 2) treatment for women diagnosed with breast or cervical cancer. The implementation of the waiver may generate a shift in the mix of PHC clients.

Data Management

Managing data and being able to report accurate information to the program continues to be a challenge for the contractors. Some contractors have been able to purchase data

management software and have programmed reporting requirements into their systems. Some contractors have been unable to purchase updated systems and continue to track information using pen and paper. Continued efforts to integrate program reporting needs with TDH supported information systems will improve the contractor's ability to correctly report the services provided and decrease the amount of missing information.

Self-Developed Performance Measures

For fiscal year 2002, PHC contractors will continue developing and tracking their own performance measures. Each contractor will set outcome, impact, and process objectives to achieve their communities' stated objectives. Contractors are expected to base the goals and objectives on the top five health indicators identified during the community assessment. Contractors will continue to provide essential medical services, however, the objectives they set are expected to enhance the preventive aspect of the PHC Program. Quarterly reporting requirements and forms may again be revised to reflect progress toward the contractors' objectives.

Competitive Grant Process

The original intent of the program was to fund the provision of health care to families without other means of accessing health care, while at the same time asking contractors to partner with other resources in the community to establish internal health care funding for families in need. Due to the amount of time required to move a community to a point that they can sustain such a funding source, the PHC grants have remained with the same agencies. As a result, the efforts to find replacement funding have waned.

Appendix

(TABLE A) **Highlights of Primary Health Care Program Data in Fiscal Years 1991-2001**

CATEGORY	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01
Total clients served	107,691	105,710	73,126	98,780	100,563	109,059	107,308	87,719	85,858	89,443	85,247
Cost per client (including all types of service)	$ 78.83	$ 79.80	$ 114.29	$ 111.72	$ 123.62	$ 118.76	$ 128.47	$ 150.19	$ 150.33	$ 178.56	$ 194.79
Cost per Diagnosis &Treatment service only	$ 18.85	$ 22.49	$ 22.49	$ 25.07	$ 24.10	$ 24.03	$ 26.54	$ 21.80	$ 21.44	$ 22.18	$ 21.17
Cost per medical service	$ 10.26	$ 12.12	$ 11.16	$ 14.04	$ 15.08	$ 14.94	$ 17.99	$ 16.80	$ 17.98	$ 26.47	$ 18.19
Total services provided	718,000	682,663	650,675	668,363	705,682	773,359	670,915	784,060	810,298	603,339	643,069
No. of clients screened and referred to all programs	82,787	76,239	121,718	162,629	173,347	158,197	161,580	157,026	165,799	156,581	131,564
No. referred to Medicaid	17,904	16,911	17,646	23,616	42,048	60,093	64,568	67,574	68,078	63,123	60,288
No. referred to CIHCP	11,473	12,996	20,769	23,080	17,386	16,116	16,553	19,401	13,204	12,584	13,817
Clients at or below 100% FPIL	72%	64%	76%	79%	77%	75%	72%	70%	73%	67%	56%
Unemployed Clients (age adjusted)	66%	67%	61%	61%	57%	54%	51%	45%	47%	48%	51%
Clients Served: Less than 1 year	w	w	w	w	1%	1%	1%	1%	1%	1%	2%
Age 1 – 4	w	w	w	w	3%	4%	5%	5%	5%	4%	4%
Age 5 – 12	w	w	w	w	11%	12%	11%	12%	11%	10%	9%
Age 13 – 19	w	w	w	w	28%	28%	18%	18%	12%	12%	9%
Age 20 – 64	w	w	w	w	51%	50%	59%	58%	65%	66%	69%
Age 65 and older	w	w	w	w	6%	5%	6%	6%	6%	7%	7%
Ethnicity: Hispanic	54%	53%	58%	58%	60%	64%	70%	67%	74%	74%	62%
White, not-Hispanic	26%	25%	21%	23%	21%	19%	18%	19%	17%	17%	15%
African American	19%	17%	19%	17%	16%	15%	10%	11%	7%	8%	6%
All other/Missing Data	1%	5%	2%	2%	3%	2%	2%	3%	1%	1%	17%

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

PHC CONTRACTORS
FUNDING AMOUNTS, NUMBER OF CLIENTS SERVED, AND COUNTIES SERVED FY01

CONTRACTORS	YRS FUNDED BY PHC	DOLLAR AMOUNT	NUMBER SERVED		COUNTIES SERVED
REGION 1			**PER RFP**	**PER AR**	
COMM HLTH CTR OF LUBBOCK [CHC]	(Since 88) 13	$188,361	1741	388	LUBBOCK AND SURROUNDING
GARZA HOSP DIST [HOSP]	(since 95) 6	$99,407	300	0	GARZA
SO PLAINS COMM ACTION ASSOC [CAP]	(since 87) 14	$150,000	350	373	DICKENS, CROSBY
SO PLAINS PUBLIC HLTH DIST [LHD]	(since 90) 11	$400,000	450	583	GAINS, TERRY, YOAKUM
SO PLAINS RURAL HLTH SERVS [CHC]	(since 87) 14	$273,681	3100	3106	COCHRAN, DAWSON, YOAKUM
REGION 2 & 3			**PER RFP**	**PER AR**	
ABILENE-TAYLOR CO PUBLIC HLTH DIST [LHD]	(since 93) 8	$266,420	2600	1829	TAYLOR
COMM HLTH SERVICE AGENCY, INC (3) [CHC]	(since 87) 14	$71,727	650	406	HUNT, FANNIN
CORSICANA-NAVARRO CO PUB HLTH DIST (3) [LHD]	(since 90) 11	$234,604	650	629	NAVARRO
CROSS TIMBERS HLTH CLINICS, INC [CHC]	(since 91) 10	$209,197	950	2193	COMANCHE, EASTLAND, HAMILTON
DALLAS CO HOSP DIST COPC (3) [HOSP]	(since 87) 14	$531,685	6253	1275	DALLAS
FISHER CO HOSP DIST [HOSP]	(since 97) 4	$96,474	485	401	FISHER
NO CENTRAL TEX COMMUNITY HEALTH CARE CENTER, INC [CHC]	(since 97) 4	$259,000	922	899	ARCHER, CLAY, COTTLE, FOARD, HARDEMAN, JACK, KNOX, THROCKMORTON, BAYLOR, MONTAGUE, WICHITA, YOUNG
SHACKELFORD CO COMM RESOURCE CTR [PNP]	(since 97) 4	$65,000	540	455	SHACKLEFORD
TARRANT CO HOSP DIST (3) [HOSP]	(since 87) 14	$300,000	13000	4125	TARRANT, JOHNSON, HOOD, WISE, DENTON, PARKER

REGION 4 & 5N			PER RFP	PER AR	
ANGELINA CO & CITIES HEALTH DIST (5) [LHD]	(since 90) 11	$195,000	2100	1121	ANGELINA
EAST TX COMM HEALTH SERVICES (5) [CHC]	(since 95) 6	$298,542	950	1524	NACODOCHES, ANGELINA, CHEROKEE, RUSK, SABINE, SAN AUGUSTINE, SHELBY
EAST TX MEDICAL CTR - QUITMAN [PNP]	(since 98) 3	$272,176	800	704	UPSHUR, WOOD, VAN ZANDT
HEALTH EXTENSIONS BY LOCAL PHYSICIANS (HELP) (5) [PNP]	(since 87) 14	$270,945	900	279	HOUSTON, TRINITY
JASPER NEWTON CO PUB HLTH DIST (5) [LHD]	(since 87) 14	$378,405	1000	539	JASPER, NEWTON
MEM MEDICAL CTR SAN AUGUSTINE (5) [HOSP]	(since 95) 6	$250,000	600	406	ST AUGUSTINE, SHELBY, SABINE, NACODOCHES, ANGELINA
PARIS-LAMAR CO HEALTH DEPT [LHD]	(since 95) 6	$211,415	1015	429	LAMAR
SAINT PAUL CHILDREN□S FOUNDATION, INC [PNP] (18 months contract, term of contract 3/1/00-8/31/01)	(since 99) 2	$276,574	800	703	SMITH, VAN ZANDT, RAINS, MORRIS, HENDERSON, CHEROKEE
TITUS CO MEMORIAL HOSP DIST [HOSP]	(since 97) 4	$111,680	1350	576	TITUS, CAMP, MORRIS FRANKLIN, RED RIVER
REGION 5S & 6			**PER RFP**	**PER AR**	
GULF COAST HEALTH CTR (5S) [GOVT]	(since 87) 14	$125,000	600	140	HARDIN
FT BEND FAMILY HLTH CTR, INC [PNP]	(since 87) 14	$381,226	3000	2994	FORT BEND
HLTH ALLIANCE OF WALLER CO, INC [PNP]	(since 93) 8	$220,307	850	682	WALLER, HARRIS
SAN JACINTO METHODIST HOSP [UNI/RES]	(since 87) 14	$352,350	986	673	EAST HARRIS, LIBERTY, CHAMBERS
REGION 7			**PER RFP**	**PER AR**	
BRAZOS VALLEY COMM ACTION AGENCY, INC [CAP]	(since 87) 14	$325,420	2700	1138	BURLESON, BRAZOS, GRIMES, LEON, MADISON, ROBERTSON, WASHINGTON
COMMUNITY ACTION, INC OF HAYS, CALDWELL, & BLANCO COUNTIES [CAP]	(since 87) 14	$343,877	762	868	BASTROP, CALDWELL, BLANCO, HAYS

LLANO MEM HEALTHCARE SYS-SAN SABA	[PNP]	(since 95) 6	$90,302	310	294	SAN SABA
WILLIAMSON CO & CITIES HLTH DIST	[LHD]	(since 88) 13	$283,440	2260	1921	WILLIAMSON
REGION 8				**PER RFP**	**PER AR**	
BARRIO COMP FAM HLTH CARE CTR, INC	[CHC]	(since 88) 13	$147,822	950	226	BEXAR
EL CENTRO DEL BARRIO	[CHC]	(since 97) 4	$250,000	2070	1278	BEXAR
GONZALES CO HEALTH AGENCY, INC	[CHC]	(since 87) 14	$90,000	1296	1395	GONZALES
SOUTH TX RURAL HLTH SERVS, INC	[CHC]	(since 87) 14	$79,238	660	540	LASALLE, DIMMIT, FRIO, MEDINA
UNITED MEDICAL CENTERS	[CHC]	(since 87) 14	$561,967	6200	6318	MAVERICK, VAL VERDE
REGION 9 & 10				**PER RFP**	**PER AR**	
ANDREWS CO HEALTH DEPT	[LHD]	(since 87) 14	$119,574	700	546	ANDREWS
CENTRO DE SALUD FAMILIAR LA FE (10)	[CHC]	(since 96) 5	$230,123	1745	1938	EL PASO
CENTRO SAN VICENTE (10)	[PNP]	(since 95) 6	$335,607	5075	4569	EL PASO
CONCHO VALLEY PROJECT	[PHR]	(since 90) 11	$210,756	750	459	CONCHO, CROCKETT, KIMBLE, MASON, MCCULLOCH, MENARD, SCHLEICHER, SUTTON
ECHD-MEDICAL CTR HOSP- FAM HLTH CTR	[HOSP]	(since 95) 6	$300,000	2000	1459	ECTOR
MIDLAND CO HOSPITAL DISTRICT	[HOSP]	(since 94) 7	$510,943	2270	1894	MIDLAND
PECOS CO MEMORIAL HOSPITAL	[HOSP]	(since 95) 6	$145,000	1650	286	PECOS AND TERREL
PROJECT VIDA (10)	[PNP]	(since 95) 6	$250,000	2000	3060	EL PASO
RIO GRANDE PROJECT (10)	[PHR]	(since 94) 7	$321,662	1000	914	BREWSTER, CULBERSON, HUDSPETH, JEFF DAVIS, PRESIDIO
LA ESPERANZA CLINIC	[LHD]	(since 88) 13	$334,000	1700	1104	TOM GREEN
REGION 11				**PER RFP**	**PER AR**	
COMM ACTION CORP OF SOUTH TEXAS	[CAP]	(since 87) 14	$641,135	2600	2661	BROOKS, JIM WELLS, AND SAN PATRICIO

LOWER RIO GRANDE VALLEY COMM HLTH MANAGEMENT CORP, INC. [PNP]	(since 97) 4	$320,000	1200	2307	HIDALGO
COMM ORIENTED PRIMARY CARE ASSOC, INC (CO P R I M A) [PNP]	(since 87) 14	$345,717	900	719	CAMERON
NUESTRA CLINICA DEL VALLE - HIDALGO [CHC]	(since 87) 14	$252,552	2600	4716	HIDALGO
LAREDO (CITY OF) HEALTH DEPT [LHD]	(since 87) 14	$200,000	501	315	WEBB
TOTAL		$13,178,311	90,841	67,654	

SDI

DENTON CO HEALTH DEPT (3) **(SDI)** [LHD]	(since 93) 8	$220,184	2100	1488	DENTON
SMITH CO PUBLIC HEALTH DIST (4/5) **(SDI)** [LHD]	(since 96) 5	$147,295	1455	3343	SMITH
FAYETTE MEMORIAL HOSPITAL (7) **(SDI)** [HOSP]	(since 97) 4	$155,541	750	1200	FAYETTE, LEE
TOTAL		$523,020	4305	6031	

PROVIDER CODES

CAP	Community Action Program (4)	PNP	Private Nonprofit Organization (11)
CHC	Community Health Center (13)	UNI/RES	University Residency Programs (1)
HOSP	Hospitals/Hospital District (9)	GOVT	Governmental Entity (1)
LHD	City and/or Co Health Dept (10)		
PHR	Public Health Region		
	Administrative Unit of Texas Dept of Health (2)		
	Total contracts 51		

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

Total all contracts 54

Texas Public Health Regions