Maternal and Child Health Services
Title V Block Grant

State Narrative for Texas

Application for 2008
Annual Report for 2006

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I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

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

C. Assurances and Certifications

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

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

D. Table of Contents

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

E. Public Input

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

The Title V application development was made available to facilitate comment throughout the 5-year needs assessment, which reflect comprehensive knowledge gained through interactions with Title V stakeholders. After its transmittal, the application will be posted on the Title V website and a notice of its availability, electronically or in hard copy, will be sent to those stakeholders who participated in the 5-year needs assessment.
/2007/ Title V grant applications are made available to the public on the DSHS MCH webpage. Hard copies are also available to Title V stakeholders upon request. //2007//

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

upon request. //2008//

II. Needs Assessment

In application year 2008, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

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

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

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

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

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

Medical Home Needs Assessment - In November 2006, all CSHCN Services Program clients received a survey about their medical home with a copy of the booklet, "Emergency and Disaster Planning for CSHCN." Of the 3,263 surveys mailed, 299 were returned. The survey asked about families' experiences with the doctor or nurse who sees their child most often. The answers are being used by staff to understand how providers are delivering services within a medical home and to develop further activities to support the concept in future efforts. The results have been shared with families and providers through the July 2007 Family Newsletter and the May 2007 Provider Newsletter found online at http://www.dshs.state.tx.us/cshcn (National Performance Measure 3)

WIC / Breastfeeding Survey - Annually, WIC surveys clients to measure attitudes, practices, beliefs, and knowledge pertaining to breastfeeding to gain further insight into barriers to breastfeeding in order to improve programmatic initiatives. In 2005, over 6,000 surveys were completed among the 76 WIC clinics. The most recent report can be found at http://www.dshs.state.tx.us/wichd/nut/neplan.shtm. (NPM 11)

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

March of Dimes Survey - As part of their efforts to address high rates of prematurity and infant mortality, the Texas Chapter of the March of Dimes implemented a pilot program to deliver positive health messages through faith-based setting for African American pregnant women. The program is ongoing in selected areas throughout Texas. DSHS Title V staff designed the evaluation for this project. Data are being collected for analysis. Results will help determine if expansion of the pilot is warranted. (Health System Capacity Indicator 5 A&B)

Child Care Health Consultants - In the summer of 2007, a survey was designed and implemented to measure the existing capacity of child care health consultants (CCHCs) throughout Texas. In addition to capacity, the survey queried payment methods, barriers to recruiting and retaining clients, depth of services provided, and frequency of services provided. The survey is designed to establish a baseline for future program development. An additional survey of the early child care facilities is planned for late summer to assess awareness and utilization of CCHCs in a rural and urban area of the state. (SPM 3)

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

East Texas Needs Assessment - The East Texas Community Health Needs Assessment represented a major effort to document health issues in 35 counties in East Texas. The purpose was to provide useful information that can assist individuals and organizations in improving health and maximizing resources. In March and April of 2007, over 1900 individual surveys were returned and 470 people provided input through community forums held in 17 cities in the region. Results of the assessment will be presented throughout the area in July and August of this year. More information can be found at the following DSHS website: www.dshs.state.tx.us/easttexas (General information on access to care and community needs)
An attachment is included in this section.

III. State Overview

A. Overview

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

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

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

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

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

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

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

This environment of change has been challenging yet stimulating to the Title V five-year needs assessment and annual planning process. As a result of these intra- and inter-agency organizational changes, Title V staff have an opportunity to work more closely with other programs and agencies (e.g. adult health care programs, mental health and substance abuse programs, and early childhood programs). HHSC has assumed a key role in leading cross-collaboration efforts among programs and agencies that serve children. While the stage has been set for enhanced collaboration, the immediate steps and adjustment involved in the consolidation have posed some challenges to communication and clarification of staff roles. The MCH and CSHCN staff will continue to work closely with DSHS leadership and HHSC, as well as with broad-based stakeholder groups, to promote progress toward the Title V performance measures throughout Texas.

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

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

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

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

We accomplish our mission by providing and supporting:
1. Essential public health services of:
- Surveillance, diagnosis and investigation of diseases, health problems and threats to the

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

2. DSHS driving principles and values of:
- Sound Mind-Sound Body, which represents an integrated approach to health that demonstrates mind/body connectedness. What is good for the body is often beneficial for the mind.
- Prevention First Approach, which is critical to the public's health, it has never been possible to overcome an epidemic simply by treatment.
- Partnering and working together to improve access to and availability of care, reduce health disparities, and eliminate the stigma of mental illness, and to build a successful public health system.

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

1. Improving Immunization Rates. Results of the 2003 National Immunization Survey (NIS) show that 78.1% of Texas children ages 19 months through 35 months were fully vaccinated in the 4:3:1 vaccine series, the highest level Texas has ever achieved. This figure represents a 9.5% increase (6.8 percentage points) over the previous year's 71.3%. While this an improvement from the previous year, Texas' vaccine coverage level has been lower that the national level since 1996. DSHS has the challenge of raising immunization levels through a collaborative effort that demands local involvement and the commitment of other state programs and agencies. This effort also requires the commitment of parents, businesses, and schools. To this end, DSHS has directed many of its efforts to build community coalitions, educate medical providers about the importance of immunizations, implement the Texas' Immunization Registry ImmTrac, and raise public awareness through a $1.5 million advertising campaign to encourage parents to get their children two years old and younger vaccinated on an age-appropriate schedule. The campaign includes billboards, radio, television and print ads in English and Spanish and focuses on selected areas with low immunization rates.
/2007/DSHS is planning to request legislative appropriations to purchase meningococcal vaccine and Human Papilloma Virus (HPV) vaccine to immunize children in need who are underinsured and present for services at any clinic site enrolled in the TVFC. //2007//

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

2. Promoting Healthy Eating and Regular Physical Activity. Overweight and obesity are associated with increased risks for several diseases including heart diseases and diabetes. Over one-third of adults in Texas were overweight in 2004. The prevalence of overweight children is far worse in Texas than in the nation as a whole. Further illustrating the priority of this issue in Texas, in 2002, Governor Rick Perry appointed an 11-member Advisory Committee on Physical Fitness to provide advice on issues relevant to physical fitness. The DSHS Commissioner was appointed to this advisory committee. At DSHS, several efforts are underway to educate individuals and communities about the benefits of physical activity and good nutrition. An example of these efforts

is the Building Healthy Families Initiative. In cooperation with Blue Cross and Blue Shield of Texas, the Caring for Children Foundation of Texas, HEB grocery stores, Texas Medical Association, Texas Hospital Association, and the American Heart Association of Texas, DSHS launched this new initiative on September 5, 2004 for a fall tour of major Texas cities. The two-part purpose of Building Healthy Families is to raise awareness of the long-term health risks associated with obesity in adults and children, and to inspire small lifestyle changes that can lead Texans to live healthier lives through exercise and better food choices. This Initiative was based on the 2003 DSHS Strategic Plan on the Prevention of Obesity in Texas. As outlined in the strategic plan, the first step in the prevention of obesity is public awareness, and that is where Building Healthy Families Initiative comes in. /2007/DSHS is planning to request nearly $3 million from the Texas Legislature to implement the Strategic Plan for the Prevention of Obesity in Texas. The implementation will allow for continued surveillance, a media campaign, rigorous evaluation, and community capacity building.//2007//

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

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

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

4. Eliminating Disparities in Health Among Population Groups. In an attempt to address growing concerns about health disparities, the 77th Legislature passed HB 757 that established the Health Disparities Task Force. The task force is charged with consulting with DSHS: 1) to eliminate health and health access disparities in Texas among multi-cultural, disadvantaged, and regional populations; and 2) to reorganize DSHS programs to eliminate those disparities. The 2004 Annual Report of the Health Disparities Task Force to the Legislature focuses on five priority health issues: immunizations, obesity, tobacco, STDs, adequate prenatal care, and organizational programmatic and policy changes. Due to the recently completed health and human services consolidation, DSHS extends the public health framework to include mental health promotion substance abuse prevention, and the stigma associated with the treatment of mental illness and substance abuse to be more challenging. One challenge we now face is to address health

disparities in a broader context. Some of the more striking disparities in mental health involve gender. Nearly twice as many women as men are affected by depression each year and more women than men attempt suicide. Yet, four times as many men as women die by suicide. Eliminating health disparities in Texas requires a commitment to identifying and addressing the underlying causes of higher levels of disease and barriers to access services in racial and ethnic minority communities. DSHS is committed to removing differences in health status, which we believe are simply unacceptable.
/2007/ DSHS is planning to request $3 million from the Texas Legislature to implement a statewide community health disparities collaborative to conduct a comprehensive analysis to track the progress in elimination of health disparities; develop standards for communicating with all Texans on health issues; support the Health Disparities Council; and provide for a health disparities coordinator in each region. //2007//

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

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

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

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

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

The success of the state's and the Title V Program's efforts to craft and implement a strategic direction depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women and children in the context of their communities. The following demographic, economic, and social trends provide an overview of some of these important characteristics for Texas.
Demographic Trends. According to the State Data Center and Demographer, by the year 2010 Texas' population is expected to grow from the current 22.5 million to 25 million. The population could be more than 51.7 million in 2040. Projected growth under all scenarios would be substantial, and in excess of Census Bureau national projections for the 50-year period from 2000-2050. Areas with the highest level of population growth include the Texas-Mexico border, Texas' central corridor from Dallas-Fort Worth through San Antonio and the Houston-Galveston area. Slower rates of growth are seen in the Panhandle, West Texas and Beaumont-Port Arthur areas. It is interesting to note, given Texas' vast geographical area, that by 2005, non-metropolitan counties accounted for only 13.5% of Texas' total population (and accounted for only 12.1% of the population increase since 2000), while metropolitan counties accounted for 86.5% of the population (and accounted for 87.9% of the population increase). Texas' population is also seeing increasing diversification and aging. As compared to all the other states in the nation, Texas has the third largest Anglo population (11,327,876), the second largest African-American population (2,588,603), the second largest Hispanic population (7,820,842) and fourth largest population of persons from other racial/ethnic groups (818,706). Texas population, like that of much of the rest of the nation, will continue to age. By 2040, nearly 1 in 5 persons will be 65 years of age or older, as compared to fewer than 1 in 10 in 2000. The issues of aging and diversification of the population are also clearly seen in the relationship between youth-status and non-Anglo status. Sixty-one percent of Texas' population aged 5 years and younger and 59% of the total population less than 18 years of age are non-Anglo. Texas is ranked 45 nationally in the number of persons aged 25 and older who completed high school, and of the 1.2 million students in public high school in 2000, approximately 12.5% dropped out. Texas socioeconomic and service structures will continue to be challenged by a population that is larger, older, and increasingly diverse. The Texas population is expected to experience the emergence of a new numerical majority. Population changes, coupled with Texas' size and complexity, will challenge Texas' resources during this century.

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

Current Poverty Rates. In 2004, 17.0% of Texas' population lived at or below poverty, showing an increase from the 14.7% reported in 2001. The issues of poverty continue to challenge state resources and impact overall health status. Hispanics were disproportionately the largest group living in poverty: among this group, the poverty rate was 59.8% in 2001, while they represented only about 35% of the general population. Anglos and others represented 26.4 of those living in poverty, and about 54% of the general population. African-Americans represented 13.8 of those living in poverty, but represent only 11.5% of Texas' general population. National estimates for 2003 indicate that 12.5% of the US population lives below poverty levels. The percentage of the population living below established poverty threshold is higher in Texas than in the nation (17% vs. 12.5%). However, poverty rates are lower in Texas compared with national rates for Anglos (7.3% vs. 10.5%) and Blacks (18.8% vs. 24.3%), and higher for Hispanics (25.2% vs. 22.5%). In Texas, those aged less than 18 years of age represent 41.6 of those living poverty, while those aged 65 plus represent 8.4% of those living in poverty. Forty-three percent of the total population

living in poverty is employed, approximately 8.9% are unemployed, and 47.9 % are not in the labor force. Forty-nine percent have less than a high school education, with only 7.9% reporting a college or higher-level degree. Over 42% of those living in poverty have either both parents or the mother present in the home. Health care coverage remains a critical need for those living in poverty. According to the same reports, only 57% of those living in poverty in 2001 reported having some health insurance coverage during 2000.

Texas Health Insurance Coverage Rates. Many national sources continue to report that Texas has the highest rate of uninsured persons in the U. S. One out every 10 people without insurance in the U.S. lives in Texas. In 2003, the last year for which full year data is available, 5.5 million Texans or 24.6% of Texas' total population were uninsured. 2003 CPS estimates that 38.6% of Texas' Hispanics and 22.7% of Texas' African Americans were uninsured. Further, they estimate that 21.5% of all children under age 18, and 24% of all Texas women go without adequate or with no health insurance coverage. Educational attainment for this population is consistent with those reporting poverty status, with 38.3% of those without health insurance having less than a high-school education and approximately 10.7% reporting a college or higher-level degree. Of those without insurance, 26.5% report being employed. Addressing these issues relative to the uninsured and underinsured is a critical factor in improving maternal and child health outcomes. Work is ongoing on several levels to address this issue.

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

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

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

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

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

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

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

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

In addition, since the CSHCN SP no longer has a formal CSHCN Advisory Committee, the program actively looks for ways to engage stakeholders in the decision-making process. The program has strengthened ties with the Texas "Parent to Parent" organization and collaborates with their Champions for Progress grant. Parents of CSHCN in various geographic locations in Texas have become Family Voices representatives to improve statewide involvement of families in systems development. Regional social work staff and the program's community-based service contractors work to facilitate family access to services, promote family networking, increase family involvement in community service system development decisions, and obtain family feedback. /2007/ Activities similar to FY05 continue. The CSHCN SP also collaborates with Texas Parent to Parent with their Family-to-Family Health Education Center grant awarded in FY06. Contractor family satisfaction is assessed, reported, and analyzed. Planning is underway for a survey to assess consumer satisfaction with the CSHCN SP health care benefits and the overall service system. //2007//

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

On the MCH side, several initiatives are being implemented in collaboration with other public and private partners to improve access to and availability of care and to focus on prevention and education to prevent health problems and improve health status of the women and children in Texas. Examples are: 1) enhancing Texas's capacity to coordinate and integrate service delivery

for all children under 6 years old; 2) providing local health care organizations with state funds to develop business plans and the infrastructure and capacity required of FQHC organizations (the initiative has resulted in more than 20 new or expanded existing FQHCs since its inception in FY 2003); 3) expanding the number of disorders screened in Texas and planning for the infrastructure and capacity required to serve newly identified children that will need confirmatory testing and follow up care; and 4) increasing access to mental health and substance abuse services for adolescents through a pilot project in which primary care physicians, family practitioners, and other medical professionals will be trained to screen, assess, and prescribe medicines to adolescents with minor mental health disorders and substance abuse problems.

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

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

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

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

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

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

- Senate Bill (SB) 316: Requires DSHS to create an informational brochure about Shaken Baby Syndrome, perinatal depression, newborn screening, and immunizations, which would be posted on the DSHS website. The bill also requires that all hospitals, birthing centers, and midwives present new parents with written or verbal information about Shaken Baby Syndrome shortly after their child's birth. The bill also requires DSHS to make a printed version of the pamphlet available to physicians.
/2007/ The pamphlet, Information for Parents of Newborn Children, has been made available in English and Spanish through the DSHS website (http://www.dshs.state.tx.us/mch/Parents_of_newborn.shtm) and warehouse. //2007//

- House Bill (HB) 790: Requires DSHS to expand the number of disorders for which newborns are tested, to determine whether the activity should be outsourced, and to plan for the expansion to the full number of tests recommended by the American College of Medical Geneticists.
/2007/ See Section IIIB. Agency Capacity for an update on the Newborn Screening Program expansion. //2007//

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

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

- SB 747: Requires HHSC to create a Medicaid waiver program expanding eligibility to women living at or below 185 percent of the federal poverty level for preventative health and family planning services, increasing access to these services and allowing the state to draw down additional federal Medicaid funding.
/2007/HHSC submitted a waiver on December 29, 2005 to the Centers for Medicare and Medicaid (CMS). Implementation of the waiver will be announced pending approval. Expanding Medicaid coverage for family planning to women at or below 185% of FPL will allow Title V dollars previously used to fund these services to expand family planning services for women with unknown immigration status and women either less than 18 or older than 44 years of age.//2007//

- HB 2475: Requires DSHS, in conjunction with the Cancer Council, to develop a strategic plan to eliminate mortality from cervical cancer by the year 2015. The strategic plan must take into account barriers to screening, current technologies and best practices, and identify gaps in service, and must be submitted to the Governor and members of the Legislature by December 31, 2006.
/2007/A steering committee headed by DSHS and the Texas Cancer Control Council was convened in December 2005 to oversee the Cervical Cancer Strategic Planning Initiative to produce a strategic plan to eliminate cervical cancer mortality by 2015. The plan is to be presented to the Legislature before the end of 2006.

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

Texas Medicaid Program
Medicaid is a jointly funded state-federal program, established in Texas in 1967 and administered by HHSC. As of January 2004, there were 2,501,804 Medicaid recipients in Texas, as opposed to 2,683,168 recipients in June 2005, representing an increase of about 2%. Of these Medicaid recipients, 1,814,940, or approximately 68%, are aged 0-18. The Medicaid caseload indicates that about one in nine Texans (2.6 million of 22.5 million) relied on Medicaid for health insurance or long-term care services. Non-disabled children make up the largest share (64%) of Texas Medicaid clients. Of the 1,814,940 children 18 years old and younger enrolled in the program as of June 2005, about 1,732,551 (95%) were receiving TANF or SSI cash payments. Medicaid funds slightly above one-half of all births in Texas. In FY 2004, Medicaid paid for about 53% or 203,083 out of 379,671 births. In FY 2004, over half (56.6%) of the pregnant women in the Medicaid program are between the ages of 18 and 24. While private insurance companies can no longer exclude pregnant women seeking health insurance, many young pregnant women are less

likely to be able to afford insurance. They are also more likely to work at low-level jobs that do not provide health coverage.

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

The expansion plan includes two managed care models: the fully capitated HMO model and a Primary Care Case Management (PCCM) model. In both models, members have a medical home through a primary care provider (PCP), from whom members receive primary care and obtain referrals to specialty care. In the HMO model, HMOs receive premiums from the state and pay providers negotiated rates to provide services to enrollees. In the PCCM model, PCPs receive a fee of approximately $3.00 per member per month from the state for acting as the PCP for their Medicaid managed care patients, and provider claims are paid on a fee-for-service basis through the state's Medicaid claims administrator. Following are key elements of the expansion:
1. For acute care Medicaid (primarily serving low-income pregnant women and children):
The HMO model will be implemented in one new service area consisting of Nueces and eight surrounding counties (Health Service Region 11).

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

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

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

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

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

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

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

Although disenrollment from CHIP in Texas and in other states could be the result of changes in employment, income, access to employer-sponsored insurance, or other factors, there is a concern among advocates and policy analysts that administrative barriers, such as re-enrollment procedures, increased cost-sharing, and confusion among parents of enrolled children are significant causes of disenrollment. As a result, an analysis of disenrollment patterns in Texas CHIP was conducted by surveying families. The major findings are the following:
- Of those children who disenrolled from CHIP, the distribution of race and ethnicity is very similar, indicating that there was no disproportionate disenrollment of any particular racial or ethnic group.
- the majority of those families who obtained coverage for their children post disenrollment enrolled their children in Medicaid, thus, remaining on a public insurance program.
- Fewer Hispanics (40%) obtained insurance upon disenrolling when compared to White non-Hispanic families (57%) and Black non-Hispanic families (56%).
- The disenrollees' age is another potential area of concern. Children who disenrolled were somewhat older than those remaining enrolled.
- Eighty-eight percent of families were aware of the renewal process and 80% thought the process was easy.

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

The recently completed Texas 79th Legislative Regular Session in 2005 appropriated $1.4 billion for CHIP. Funding covers projected increases in client caseloads, addresses cost growth, adjusts

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

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

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

Movement of Children Between CHIP and Medicaid.

Once a child has left either CHIP or Medicaid, HHSC examines records for the following year to find out whether the child enrolled or re-enrolled in Medicaid or CHIP. The analysis of the movement of children between Medicaid and CHIP revealed that in FY 2004:
a. Of the 379,009 children who left CHIP, 158,378 or 42% enrolled in Medicaid and 73,980 or 20% re-entered CHIP during the next 12 months.
b. Of 887,224 children who left Medicaid, 91,090 (10%) enrolled in CHIP and 364,526 or 41% re-entered Medicaid during the next 12 months.

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

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

B. Agency Capacity

I. MCH Population
Because the Title V program primarily provides MCH services through contracts with local providers, it is critical that the agency has the capacity to ensure that these providers execute competently. Three areas of the agency provide the staffing, policies and guidelines, training and technical assistance, and quality assurance needed to support providers. Two of these areas, the Preventive and Primary Care Unit (PPCU) and the Performance Management Unit (PMU), are located in the Family and Community Health Services (FCHS) Division. The third area

encompasses the health services regions located throughout the state. PPCU oversees the development of clinical policies and operational processes to assist contractors in delivering clinical services. Medical consultant Dr. Janet Lawson, an obstetrician/gynecologist, provides leadership in the development and clarification of clinical policies and protocols for community health services programs. Other staff members maintain expertise in national health standards, guidelines and best practices and provide clinical and technical support services to contractors. The unit also develops and implements professional education opportunities for clinical and administrative contractor staff to support service delivery. Clinical staff review and approve local clinical protocols, standards and procedures and provide support to required advisory committees, such as the Information and Education Committee for Family Planning and the Advisory Committee for Breast and Cervical Cancer Control.

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

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

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

The PMU has primary responsibility for quality assurance (QA) and quality improvement (QI) activities for contracted community health services, including Title V-funded services. The QA activities ensure that contractors comply with program rules, policies, and procedures for clinical and administrative areas. The QA site visits are based on risk assessments, and contractors are required to submit corrective action plans for areas found to be out of compliance during the review. Within the PMU, Quality Management Branch (QMB) staff coordinates the development of QA review tools. The QI activities focus on an analysis of QA results and outcomes. Common performance problems are tracked and reviewed with relevant staff. Research is conducted for national community health services standards, and staff develops QA targets for performance

issues to assist with contract management and to ensure that quality services are provided.
/2007/ A service improvement process is currently underway within DSHS to centralize the five major contract processes of planning, procurement, management, monitoring and closeout at the agency level and to streamline division processes that contribute to the centralized processes. Title V staff participate in the FCHS Division contract transition workgroup to provide input to the agency-side workgroup. //2007//

DSHS and the Title V program operate within a structure defined by 11 health service regions for the provision of essential public health services to all Texans. The Title V program funds several positions based in regional offices to provide: 1) public health services, including core public health services and direct health care, in areas with no local health department (141 out of 254 counties have no public health presence); and 2) technical assistance, contract management, and quality assurance and quality improvement activities for all Title V-funded providers in their assigned regions. Consistent with Title V priority needs and related activity plans for FY 06, Title V program areas work with each public health region to develop, implement and monitor service level agreements (SLAs) in the areas of population-based services, quality assurance, vision and hearing, contract monitoring, and direct services. Each SLA amounts to a contract between the State Title V Director Office and each PHR and provides quantifiable time-specific performance measures, activities, and outcomes that each Title V-funded public health region agrees to complete during specified timelines. Title V central and regional work together to develop and finalize the SLAs.
/2007/ In the agency structure, HSRs function within RLHS, currently located within the scope of the Center for Program Coordination and reporting to both Deputy Health Commissioners. In the fall of 2006, RLHS is to be reconfigured as a fifth Division within DSHS and will report directly to the Commissioner of Health. HHSC Executive Commissioner, Albert Hawkins, approved the pending reconfiguration in August 2005. Due to the significance of the HSRs' role in assuring the essential public health functions, DSHS assembled an internal work team to examine the agency's role in assuring essential public health standards. Input was sought from an array of public health partners that included the Title V Director. Although the work is ongoing, progress was achieved in defining DSHS's role in assurance of the standards, identification of factors affecting the costs of the standards, and identification of ways to strengthen linkages between mental health, substance abuse and the standards. With declines in federal funds that support RLHS, DSHS is planning to request $12.4 million from the Texas Legislature to ensure that these services can continue. //2007//

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

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

The Center for Program Coordination (CPC) strives to improve the overall performance of DSHS as well as the connections between the agency and its employees. Central to this work is the DSHS Workplace Improvement Plan, which focuses on agency strategic priorities in three areas--attracting and developing the best public health and behavioral health services; encouraging innovation and results-oriented government performance; and engaging employees in improving agency business and program practices. CPC has four primary functions. The first is program integration and coordination within DSHS and the HHHS umbrella and other related state agencies. The second is business process improvement, including mapping agency business

practices, making recommendations for improvements, ensuring the use of consistent standards and practices, training on project management tools; and evaluating and maintaining benchmarks for department operations and service delivery. The third is leadership and management development, and the fourth is workplace improvement, including implementing the DSHS Workplace Improvement Plan.

/2007/ The CPC continued to facilitate the DSHS process for workplace improvement throughout 2006. Last fall, the DSHS Commissioner approved two agency-wide workplace-improvement initiatives. The first, "3 in 30," refers to identifying three priorities from the 14 recurrent themes, which was completed in December 2005 by DSHS organizational areas (divisions, regions, hospitals, and centers). The DSHS leadership team also developed strategies for three agency-wide priorities identified by senior management, regional directors, and hospital superintendents. The second initiative is "Success in 60." Over the first 60 days of 2006, each DSHS organizational area developed a work plan with strategies and activities in the three areas identified for improvement. The goal was for identification and initial implementation of strategies to be completed by March 1, 2006; however, some strategies may be longer term.

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

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

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

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

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

/2007/ The DSHS Promotor(a) or Community Health Worker Training and Certification (CHW) Program convened a workgroup consisting of DSHS programs to collaborate with the CHW Program in developing a strategic plan to increase the program's effectiveness. The workgroup charge is to identify resources to support the mission and goals of the CHW Program and

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

The DSHS laboratory facility conducts tests for large health screening programs and for public health programs, including clinical testing for infectious diseases and environmental testing for chemical contaminants. Routine activities include providing laboratory testing for the newborn screening program, the Texas Health Steps Program, and women's health services including cervical cancer screening; providing prenatal screening to determine the risk of Down's Syndrome, Trisomy 18, and neural tube defects. The laboratory provides selected clinical testing free-of-charge to all Title V-funded providers.
/2007/ November 1, 2006, is the targeted implementation date for the Newborn Screening (NBS) Program expansion. The number of disorders will increase from five to 27 and will include but not be limited to testing for four Fatty Acid Oxidation disorders, nine Organic Acid disorders, and Biotinidase Deficiency. As a result of the study on outsourcing, lab services for NBS will remain in-house with DSHS. Tandem mass spectrometry (MS/MS) technology will be utilized and 10 MS/MS instruments will be installed as part of a laboratory retrofit to accommodate the instruments. Increased capacity to meet the need for expanded case management throughout the state will include 16 FTEs in the health service regions and additional central office staff. Outreach and provider education, including continuing education credits for providers, will be enhanced. //2007//

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

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

OEHD supports the efforts of the Health Disparities Task Fore, created in the 77th Legislative Session, to eliminate health and health access disparities in Texas among multicultural, disadvantaged and regional population. The work of the OEHD and the Task Force has concentrated on six health topics: childhood immunization, obesity, physical activity and fitness, tobacco use, responsible sexual behavior and adequate prenatal care. In its 2004 report, the Task Force made a series of recommendations around each of these topics including increasing state funding and other resources to address them, expanding health promotion efforts and prevention programs and strengthening partnerships inside and outside DSHS. The Task Force

also recommended maintaining the elimination of health disparities as an agency focus; the implementation of an internal workgroup for the elimination of health disparities; and the development of a cultural competency training program for DSHS staff and providers that could be replicated in other health and human service agencies. Both the OEHD and the Task Force work to guide and support DSHS programs in their efforts to eliminate health disparities related to their focus areas.
/2008/ Effective 9/1/07, the OEHD and the Task Force will be placed in the HHSC and will work with all health and human services programs.//2008//

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

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

The State Committee is a multidisciplinary group comprised of members throughout Texas. Its mission is to reduce the number of preventable child deaths and its purpose is threefold:
· To develop an understanding of the causes and incidence of child deaths in Texas;
· To identify procedures within the agencies represented on the Committee to reduce the number of preventable child deaths; and
· To promote public awareness and make recommendations to the governor and the legislature for changes in law, policy, and practice to reduce the number of preventable child deaths.
CFRTs are multidisciplinary, multiagency working groups that review child deaths on a local level from a public health perspective. By reviewing circumstances surrounding child deaths, teams identify prevention strategies that will decrease the incidence of preventable child deaths. The review process also provides an opportunity for an ongoing needs assessment for Title V.

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

/2008/In addition, at DSHS, Title V is working with the Mental Health and Substance Abuse Division and Texas Tech University to provide continuing support to the Texas Adolescent Mental Health in Primary Care Initiative (TAMHPCI). The goal is to improve the mental and physical health of adolescents through private and public partnerships and sustainable system changes and a feasibility study is near completion. Initial results are very

promising and all indicators point that with slight adjustments in implementation, the TAMHPCI model could be instrumental in transforming not only behavioral health care, but also in implementing evidence-based protocols for other public health concerns.//2008//

II. CSHCN
CSHCN SP provides a comprehensive array of health care benefits (HCB) including: evaluation and diagnosis; physician visits; inpatient and outpatient hospital services; orthotics and prosthetics; medical equipment and supplies; nutritional supplements and counseling; medications; speech, language, physical, and occupational therapy; meals, lodging, and transportation to receive medical treatment; and family supports to CSHCN who meet a broad functional definition of "children with special health care needs," not just children with specific diagnoses, and adults with cystic fibrosis. The CSHCN SP provides health care benefits that are not covered by other third party payers. The program is the payer of last resort, after Medicaid, CHIP, and private insurance. The CSHCN SP enrolls and reimburses individual HCB providers throughout the state on a fee-for-service basis. Currently, due to budgetary constraints and the fact the CSHCN SP is not an entitlement program, the CSHCN SP continues to have a waiting list for HCB, which was instituted in October 2001.
/2007/ The CSHCN SP waiting list continues, however, clients are released as funds are available. The program has developed policy to allow coverage for clinician-directed non face-to-face care coordination to help reimburse for medical home services.

Title V CSHCN staff are also active in numerous state and national associations and advisory groups in order to retain subject matter expertise in CSHCN issues. Some of these affiliations include AMCHP, the Children's Policy Council, the Texas Council on Developmental Disabilities, the Texas Pediatric Society, the Community Resource Coordinating Groups State Council and the Texas Center for Disability Studies. //2007//

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

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

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

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

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

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

February 28, 2007. //2008//

In addition to HCB, the CSHCN SP annually provides extensive case management services throughout the state to more than 26,000 families and their CSHCN through DSHS Regional social work staff. Through service contracts with community-based organizations additional case management, FSS, and clinical care are provided to over 15,000 families and their CSHCN each year. Case managers (both staff and contractors) provide a critical statewide infrastructure for continuous efforts to: improve awareness of and access to the CSHCN Services Program health care benefits; coordinate state and community-based service systems; and achieve the Title V performance measures.
/2007/ For FY06 the CSHCN SP improved data collection systems to provide more accurate counts of CSHCN and their families receiving case management through CSHCN SP regional staff and case management, family support and clinical services through CSHCN SP contractors. These changes to reduce data duplication and clarify definitions may impact the reported number of families served. //2007//

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

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

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

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

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

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

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

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

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

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

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

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

C. Organizational Structure

The Department of State Health Services (DSHS) is the state agency responsible for administration of the Title V Program and is one of four state health and human services (HHS) agencies under the umbrella of the Texas Health and Human Services Commission (HHSC). HB 2641 of the 76th Texas Legislature and HB 2292 of the 79th Texas Legislature enhanced HHSC's

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

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

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

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

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

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

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

-DSHS Commissioner Sanchez announced on June 2004 the appointment of Dave Wanser,

Ph.D., as the DSHS Deputy Commissioner of Behavioral and Community Health. Dr. Wanser served as the Executive Director of the Texas Commission on Alcohol and Drug Abuse (TCADA) and is chair of the statewide Drug Demand Reduction Advisory Committee. Prior to that, he spent 14 years at the Texas Department of Mental Health and Mental Retardation, where he was director of the NorthSTAR Behavioral Health Program and director of behavioral health services.

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

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

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

The Title V & Health Resources Development Office includes the general administration of the Block Grant, Women's Health Area (e.g., maternity and perinatal health, breastfeeding, and domestic violence), Children's and Adolescent Health Area (e.g., early childhood, adolescent mental health, teen pregnancy), the Service Delivery Initiative, and the Texas Primary Care Office (TPCO). This offers opportunities to provide a focal point for women and children's matters and policy development, and the coordination and integration of resources of Title V and TPCO (i.e., J-1 visa waiver and the Incubator FQHC Initiative) to improve access to services for low-income families in underserved areas. The Office also funds initiatives and projects across and outside the agency. The State Title V Director has the responsibility of managing the Title V & Health Resources Development Office and reports to the Assistant Commissioner for FCHS.
/2007/ In February 2006, the Offices of Title V & Health Resources Development and Research & Public Health Assessment were merged. This merger consolidated these two offices into the Office of Title V and Family Health Planning. This newly created office includes three administrative units -- the Family Health Research and Program Development Unit, the Health Data and Reporting Unit, and the Texas Primary Care Office. The objective of the reorganization was to (1) improve synergy between research and practice to inform policy development, (2) promote the development of evidence-based programs, and (3) develop best practices leading to an improved understanding and response to the health and health care needs of the Texas women, adolescent, child, and infant population. Attachment D shows Title V funding and resources allocation within DSHS. //2007//

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

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

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

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

elevating Regional and Local Services to the Division level will benefit Title V by providing a sound foundation for building and enhancing local infrastructure. The existence of functioning, well-supported regional offices ensures local Title V representation as well as a direct connection to Title V contractors. Regional staff often serves in multiple functions, meaning that they have the opportunity to network and make relevant connections with other programs that can contribute to improving maternal and child health and to enhancing the local public health infrastructure.

An attachment is included in this section.

D. Other MCH Capacity

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

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

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

The Research & Public Health Assessment (R&PHA) Office provides the MCH epidemiology support to the FCHS Division. The primary services include expert statistical analysis, data management and program reporting, geographical/spatial analysis, Title V performance measures, research design and consultation, epidemiological analysis and literature reviews, case finding and active surveillance via PRAMS. R&PHA is also responsible for the State Systems Development Initiative (SSDI) and coordinates a blending of activities with PRAMS to assure existing statewide surveillance.
/2007/ R&PHA and the Title V and Health Resources Development Office have merged to establish the Office of Title V and Family Health Planning to improve synergy between researchers/statisticians and Title V subject matter experts. Under the oversight of the Title V MCH Director, the new office includes 1) the Family Health Research and Program Development Unit, responsible for expert statistical analysis, geographical/spatial analysis, research design and consultation, epidemiological analysis, literature reviews, and the SSDI Grant; and 2) the Health Data Assessment & Reporting Unit, responsible for data management, program reporting, and the operations of PRAMS.

Through the new structure, Title V has initiated meetings with university partners to explore possible collaborative efforts to develop or test best practices and enhance surveillance activities. Title V seeks to formalize relationships with university partners to continue to strengthen the evidence-base for all programmatic activities and increase the MCH knowledge base in Texas. //2007//

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

Below are summaries of the qualifications of senior level employees:

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

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

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

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

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

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

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

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

Fouad Berrahou, Ph.D., was named State Title V Director effective July 2002. Dr. Berrahou is the Director of the Title V and Resources Development Office and primarily responsible for coordinating the management and administration of the Texas Title V program and reports

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

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

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

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

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

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

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

Dr. Walker has been employed at DSHS (TDH prior to September 2004) for 19 years. From December 2002 until September 2004, she served as the Medical Director/ Director of the Public Health Policy Unit of the CSHCN Division in the Bureau of Children's Health and the Texas Title V CSHCN Director. From June 2002 through November 2002 she served as the Acting Director

of the Children with Special Health Care Needs (CSHCN) Division. From September 1996 until June 2002, she served as the Director of Systems Development in the CSHCN Division. From May 1994 to September 1996, she was the Director of Special Initiatives in the Children's Health Division, focusing on special initiatives pertaining to CSHCN. From October 1993 to May 1994 she was the Director of the Children's Health Division, which included the Chronically Ill and Disabled Children's Services Program (CIDC; currently the CSHCN Program) as well as EPSDT (now Texas Health Steps). From April 1993 to October 1993 she served as the Acting Bureau Chief for the CIDC Bureau. From May 1986 to April 1993 she was the Medical Director for the CIDC Bureau.

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

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

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

/2007/ Mike Montgomery is the Director of the Nutrition Services Section. He has more than 30 years experience with WIC, having served across the spectrum of management and administration in positions at the federal, state, and local level. He came to the Department of State Health Services (DSHS) in 1996 to serve as the leader of the Texas WIC project development team for the Electronic Benefits Transfer (EBT) project. //2007//
An attachment is included in this section.

E. State Agency Coordination

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

practices experiences and working to develop a network of local women's health networks within Texas. Alliance meetings also serve as a format to provide members with state of the art information on health issues impacting women and on federal efforts to improve the status of women's health throughout the lifespan. The Title V Perinatal Health Coordinator serves on the Alliance for Region VI.

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

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

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

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

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

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

V-funded clinics providing preventive health services.

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

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

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

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

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

Through the Federally Qualified Health (FQHC) Incubator Grants Initiative, DSHS provides funding and technical assistance to local entities interested in pursuing FQHC designation so they can develop a competitive application at the federal level. The Texas Primary Care Office (TPCO) collaborates with the Texas Association of Community Health Centers (TACHC) to

provide training and TA to these entities. Both TACHC and TPCO share the common goal of growing the number of FQHCs serving the state, thereby improving access to care for low-income families in underserved areas. TPCO is under the oversight of the State Title V Director.

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

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

Title V staff have working relationships with the Texas Medical Association (TMA) as well as the professional organizations for pediatricians, family practice doctors, obstetrician-gynecologists, certified nurse midwives and direct entry midwives. Through these relationships, information, knowledge and resources are shared and entities work to further joint projects and common goals. Title V staff communicate regularly with TMA staff on events and activities at both organizations. TMA is represented on maternal and child workgroups at DSHS, including the PRAMS Advisory Committee and the Perinatal Depression Provider Partnership coordinated by Title V program. Title V staff also provide information for the TMA Committee on Maternal and Perinatal Health meetings. The agencies have partnered on activities, such as the development of a letter from physicians to employers regarding the benefits of supporting their employees who desire to pump breast milk during the workday in order to maintain breastfeeding.

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

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

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

Texas Perinatal Association (TPA) provides perinatal education for doctors, nurses, administrators and other personnel in the rural communities in Texas, primarily through conferences and workshops. The TPA is a critical resource for conveying information to providers

about Texas Title V activities. Regional Title V staff work with TPA to produce two regional conferences a year to educate providers on issues relevant to improving perinatal outcomes in Texas.

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

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

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

CSHSN

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

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

/2007/ New members to the Medical Home Workgroup (MHWG) in FY06 included family practice physicians, representatives of the Texas Association of Community Health Centers, Texas Health Steps, and Newborn Hearing Screening staff. Participation has strengthened the workgroup's

efforts related to the Medical Home Strategic Plan. Increased collaboration between the CSHCN SP and HHSC Medicaid Program resulted in health care benefits policy development, proposed medical home inservice training, and increased awareness among Medicaid/CHIP managed care organization medical directors. The Medical Home Strategic Plan has been incorporated into the Texas Early Childhood Comprehensive Systems plan. This plan is addressed in the HHSC strategic plan. //2007//

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

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

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

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

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

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

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

A CSHCN SP staff member is the DSHS agency representative on the Interagency Council on Autism and Pervasive Developmental Disorders, established by legislation in 1987. The Council is composed of seven family members, appointed by the governor, and representatives from five state agencies, appointed by the commissioners of the respective agencies. The Council

develops a state plan that identifies and articulates the needs of individuals with autism and other PDDs, makes recommendations to state agencies providing services, and advises the Texas Legislature about legislation needed to develop and maintain quality intervention and treatment services.

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

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

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

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

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

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

F. Health Systems Capacity Indicators

Introduction

The Health Status Capacity Indicators (HSCIs) for Texas identify areas of great improvement and areas in need of attention. There have been steady declines in the asthma hospitalization rate up to 2005. In 2006, the rate declined 25%. This decline represents both a cost savings to the

Texas health care systems and an improvement in quality of life for Texas's children. Another significant improvement is seen in the area of preventive health. Since 2001, there has been a 41.6% increase in the number of infants who received at least one initial periodic screen. In addition to these successes, the HSCIs identified areas for improvement in Texas. Indicators for prenatal care, low birth weight, and infant mortality all lag behind 2010 objectives. There is also a significant disparity between Medicaid and non-Medicaid populations. To address these indicators, as indicated by Health Status Indicator 6C, Texas continues to explore methods for expanding Medicaid and CHIP coverage. In addition to expanded coverage, Texas has conducted and shared the results of a Perinatal Periods of Risk Analysis, has funded several projects aimed at addressing disparities in the adequacy of prenatal care, has analyzed and promulgated results of Texas PRAMS. Texas will continue to use data to inform initiatives and interventions that will reduce the disparities in these indicators and contribute to achieving internal state targets and national HP2010 objectives.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	38.8	35.7	34.4	25.9	24.2
Numerator	6520	6115	6161	4745	4566
Denominator	1680867	1712778	1793350	1835331	1883567
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
Data is an estimate based on a linear trend of 2002 through 2005.

Notes - 2005
Data is an estimate based on a linear trend of 2001 through 2004.

Notes - 2004
Sources:
Hospitalizations - Texas Hospital Inpatient Discharge Public Use Data File. Texas Health Care Information Council (THCIC), Austin, TX, 2004.

The 2000-2004 data is based on hospitalizations, not individuals. These numbers may be an underestimation of the true rate of hospitalizations for asthma because Texas hospitals located in counties with populations less than 35,000 are exempt from reporting to the THCIC.

Population - Texas State Data Center, Texas Population Estimates and Projections, June 2006.

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

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

1) Informing health care providers, patients and families, the public, payers, employers, and governmental partners about:
a. The elements of evidence-based, state-of-the-art asthma care
b. The personal and societal burden that asthma imposes
c. Misconceptions and myths about asthma
d. Barriers to optimal asthma care

2) Promoting research to improve the delivery of asthma care in Texas and to delineate the role of the environment in the development and exacerbation of asthma

3) Communicating with local asthma coalitions, health care providers and provider organizations, patients and families, community-based organizations, and governmental partners

4) Disseminating information about Texas asthma projects, resources for patients and providers, developments in asthma care and research, and data on the health of Texans with asthma

5) Collaborating with groups to improve indoor and outdoor air quality

6) Encouraging and supporting activities that measure the health of Texans with asthma

7) Advocating for rules, policies, and laws that advance the vision of the Asthma Coalition of Texas.

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

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	70.6	93.5	98.7	96.4	100.0
Numerator	158431	223304	245083	244236	258808
Denominator	224388	238851	248232	253418	258808
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
100% reported on CMS-416. Numerator and denominator had slight differences due to data reporting system.

Source:
Texas CMS-416 FFY 2005 - 2006

Notes - 2005
Notes:
The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Source:
Texas CMS-416 FFY 2004 - 2005

Notes - 2004
Notes:
The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Source:
Texas CMS-416 FFY 2003 - 2004

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

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	2.0	0.7	0.4	41.7	38.5
Numerator	14549	5407	2823	1600	1243
Denominator	727452	727434	651054	3837	3226
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006
Prior to 2005, denominator data included all Texas SCHIP recipients.

Source:
Texas Health and Human Services Commission (HHSC).

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

Notes - 2004
Sources:
2002 - Texas Health & Human Services, Children's Health Insurance Program in Texas.: The New Enrollee Survey Report 2003, March 2003.
Centers for Medicare and Medicaid Services, SCHIP Preliminary Annual Enrollment Report for Fiscal year 2002. http//www.cms.hhs.gov/schip/enrollment

2003 - 2004 Update: Texas Health & Human Services Commission.

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

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

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	69.7	70.3	69.9	74.8	79.3
Numerator	258393	265305	265673	292636	311358
Denominator	370983	377374	380056	391482	392830

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

Notes - 2006
Data is a linear trend projection using data from 2001 through 2005 (as of 7/16/07.)

Notes - 2005
Data is a linear trend projection using data from 2001 through 2004 (as of 7/16/07.)

Notes - 2004
Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

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

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Indicator	55.4	60.0	62.1	62.9	64.5
Numerator	846963	1098882	1253626	1317797	1370299
Denominator	1529942	1831982	2017859	2095657	2123317
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006
Source:
CMS-416 FFY 1997-2006

Notes - 2005
Source:
CMS-416 FFY 1997-2005

Notes - 2004
Source:
CMS-416 FFY 1997-2004

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

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

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Indicator	51.4	55.2	56.0	56.3	55.2
Numerator	194057	250718	287357	301346	308987
Denominator	377746	454423	512778	535079	559406
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006
Source:
Texas CMS-416 FFY 2006.

Notes - 2005
Source:
Texas CMS-416 FFY 2005.

Notes - 2004
Source:
Texas CMS-416 FFY 2004.

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

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

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Indicator	68.5	NaN	54.6	47.3	25.1
Numerator	31289	0	35758	35758	21088
Denominator	45689	0	65476	75528	83891
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006
Total SSI Recipients under 16
Source: SSA, Supplemental Security Record - December 2006

Total SSI Recipients under 16 Receiving Rehabilitation Services
Source: from the Health Screening and Case Management Unit and the Purchased Health Services Unit for the CSHCN Services Program.

Notes - 2004
All SSI recipients in Texas obtain health care benefits coverage through Medicaid. Considering the broader spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach and case management services through CSHCN Title V efforts.

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

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

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2003	payment source from birth certificate	8.1	7.5	7.9

Notes - 2008
The most current available birth record for the State of Texas is 2003.

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

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2003	payment source from birth certificate	7.7	6	6.6

Notes - 2008
The most current available birth record for the State of Texas is 2003.

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

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2003	payment source from birth certificate	75.2	82.2	79.7

Notes - 2008
The most current available birth record for the State of Texas is 2003.

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

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

INDICATOR #05	YEAR	DATA SOURCE	POPULATION		
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			**MEDICAID**	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2003	payment source from birth certificate	70.1	70.5	70.4

Notes - 2008
The most current available birth record for the State of Texas is 2003.

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

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2006	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

Infants (0 to 1)	2006	200

Notes - 2008
Sources:

Selected HHS Program-Related Percent of Federal Poverty Income Levels (FPL's) for 2006

(http://www.hhsc.state.tx.us/research/dssi/PS/PgmPovertyLevels.html).

Based on Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia, Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Prepared by: DSHS, FCHS-HDAR, February 2006. Data was rounded up as specified by CMS/HHS directive.

Notes - 2008
Sources:

Selected HHS Program-Related Percent of Federal Poverty Income Levels (FPL's) for 2006

(http://www.hhsc.state.tx.us/research/dssi/PS/PgmPovertyLevels.html). Based on Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia, Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Prepared by: DSHS, FCHS-HDAR, February 2006. Data was rounded up as specified by CMS/HHS directive.

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

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range 19 to 20)	2006	 133 100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2006	 200

Notes - 2008
Medicaid recipients who are 19-20 either qualify for SSI and receive Medicaid, or are in transitional groups including youth transitioning from foster care.

Non-disabled, non-pregnant adults under age 65 must be parents and/or related caretakers of children with income below the TANF limit to receive Medicaid benefits. Children under age 19 and pregnant women with income over the limit who have medical bills that, if deducted from income, reduce income to a specified income limit ($275 per month and assets under $2,000 for a family of three), may be eligible for Medicaid coverage of additional medical bills. A straight percentage of the FPL is not used. Data system would not allow entry of a number below 100%.

Notes - 2008
To qualify for CHIP, a child must be under age 19.

As of 1/2/07, CHIP began providing a perinatal benefit to unborn children of pregnant women who do not qualify for Medicaid, with income up to 200% FPL, and who meet the other eligibility requirements.

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

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2006	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		200

Notes - 2008
Sources:

Selected HHS Program-Related Percent of Federal Poverty Income Levels (FPL's) for 2006

(http://www.hhsc.state.tx.us/research/dssi/PS/PgmPovertyLevels.html).

Based on Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia, Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Prepared by: DSHS, FCHS-HDAR, February 2006. Data was rounded up as specified by CMS/HHS directive.

Notes - 2008
On 1/2/07, A new benefit of CHIP extended coverage for an unborn child of non-Medicaid eligible women for up to 12 months. To be eligible the income must be below 200% FPL.

Narrative:

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

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

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2008

Narrative:
Infant Birth and Death Certificates

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

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

Current Status: DSHS currently has the capacity to link birth records and Medicaid data. Texas

requires significant time and resources to manage and link these types of data due to 350,000 births and millions of Medicaid eligibility records and/or claims generated per year.

Annual linkage of birth certificate and WIC eligibility files

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

Annual Linkage of birth certificate and newborn screening files

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

Hospital Discharge Surveys

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

Annual Birth Defects Surveillance

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

PRAMS

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

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

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

Notes - 2008

Narrative:
Youth Risk Behavior Survey

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

Texas School Survey

Current Status: Texas Commission on Alcohol and Drug Abuse (TCADA) in collaboration with the Public Policy Research Institute at Texas A&M University conducted two statewide surveys of drug and alcohol use among students in elementary and secondary schools. Reports of these surveys are currently available for 1988 through 2004. Surveys are only conducted in public schools therefore private school students and dropouts are not represented in the sample. Estimates of substance use in this survey are based on self-reports.

Behavioral Risk Factor Surveillance System

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

PRAMS

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

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

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

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

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

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

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

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

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

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

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

B. State Priorities

Title V is concerned about the health and well being of all Texas residents. As shown in the needs assessment section, indicators show improvement in many areas of the health of Texas' population. Others, however, show discouragingly little progress. As part of Texas' effort to improve health status and eliminate health disparities within the entire Title V population, Title V staff members include the following priority focus areas, highlighting priority needs for this reporting period. The priority focus areas are organized by population group and service levels of the pyramid.
/2007/ No updates were added for FY07. //2007//

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

I. Women and Infants

Infrastructure Building
Reduction of domestic violence
Title V stakeholders identified domestic violence as a priority need for women and infants in the 2005 needs assessment. Reducing the incidence of domestic violence has been a priority need in Texas for Title V since being added as a state priority in 2002. The need has been well documented. In 2002, researchers conducted the first surveys of sexual assault and domestic violence prevalence in Texas, providing critical state-level data that documented the need (Busch et al., A Health Survey of Texans, 2001; and Texas Council on Family Violence, Prevalence, Perceptions, and Awareness of Domestic Violence in Texas, 2003.) The survey, which focused

on sexual assault, found that nearly two million Texans have been sexually assaulted at some time in their lives and that nearly one in ten Texas girls were assaulted before they reached age 14. The domestic violence study reports the problem as an epidemic in Texas, with 47 percent of all Texans having been abused in their lifetimes. Both studies confirm that these forms of violence are underreported. The Healthy People 2010 goal for intimate partner violence is to reduce it to 3.6 physical assaults per 1,000 persons aged 12 years and older. Texas does not maintain statistics in a manner consistent with HP 2010, but available data would indicate that currently, the rate in Texas is much higher.

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

Population-Based

Reduction of obesity among women (new need)

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

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

Although reducing adult obesity is a new priority for Texas, early research is showing that multi-factor interventions can have a positive impact on the rate of overweight and obesity. (William H. Dietz, M.D., Ph.D., CDC's Role in Combating the Obesity Epidemic, Statement before the Senate

Committee on Health, Education, Labor and Pensions, May 21, 2002.) While much remains unknown about the impact of overweight and obesity on perinatal outcomes, what is known confirms that being at a healthy weight going into pregnancy increases the likelihood of a less complicated pregnancy and delivery.

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

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

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

II. Children and Adolescents

Population-Based
Reduction of obesity among children
Obesity is linked to decreased physical activity, diabetes, cardiovascular disease, joint pain, mobility problems, and other long-term health complications. Texas mirrors the national trend of increased overweight and obesity in children. In 2003, the national average was 13.5% while Texas was slightly higher at 13.9%, both increasing from approximately 10% in 1999. The highest incidence in Texas children ages 1-4 is among Hispanics, which continues to be a rapidly growing population within Texas. Preventing obesity is a priority objective for the Governor of Texas and the DSHS Commissioner. After reviewing both perceived and actual needs, Title V subject matter experts and stakeholders identified obesity as a critical issue and thus selected it as a state priority need. While many evidenced-based interventions exist to curb obesity among children, it is strongly believed that teaching parents of very young children healthy nutritional habits can positively impact children through adulthood and minimize the number of chronic diseases associated with overweight and obesity. Thus, the desired outcome of the reduction of obesity is intended to decrease the child death rate per 100,000 children aged 1-14.

Infrastructure Building
Increase access to dental care (new need)

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

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

III. CSHCN

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

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

The four selected state priorities (NPM 2, 3, 5, and 6) reflect the current capacity and focus of Title V activities and influence. Due to the interconnectedness of all the Title V CSHCN performance measures, the activities in these areas incorporate activities to achieve NPM 4 and

SPM 1 as well. Specific activities for all national performance measures and the one state-added performance measure are planned in FY06.

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

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

C. National Performance Measures

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

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	95	95	95	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	401	426	383	377	370
Denominator	401	426	383	377	370
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100

Notes - 2006
Denominator is number of confirmed cases as indicated on Form 6.

Notes - 2005
Denominator is number of confirmed cases as indicated on Form 6.

Notes - 2004
Denominator is number of confirmed cases as indicated on Form 6.

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

Update: Through August 2006, 7,982 (2.1%) of 379,750 total samples received were unsatisfactory. The number of contacts made with providers submitting unsatisfactory samples was 265.

The following number and type of educational materials were distributed:
Practitioner's Guide -- 1,060
New Submitter Packet -- 188
Weight Conversion Chart -- 560
Specimen Collection Guide -- 1,987
Specimen Collection Posters -- 967
CD Slide Presentations -- 108
Newsletters -- 15,839
Urgent Message Flyers -- 3,903

The Texas NBS Program provided educational materials for residency training at Wilford Hall USAF Hospital, San Antonio. Specimen collection materials were provided for in-service training at Parkland Hospital in Dallas, Presbyterian Hospital of Allen, Hermann Hospital of Houston and a clinic in San Marcos. In collaboration with the state laboratory EPSDT program, specimen collection training was provided in Houston, Beaumont and Austin. Clinical Chemistry Expert Forums were held in San Angelo, Midland and El Paso. NBS participated in the Austin Area Health Fair. NBS prepared an article for the Texas Hospital Association newsletter regarding how the 'batching' of specimens can result in specimens being too old to test. NBS had an information booth at the Annual Vital Statistics Conference in Austin. NBS prepared a promotional poster for the Mountain States Genetic Network (MOSTGENE).

NBS Case Management began an in-service education component in July 2006. Through August 2006, in-services were held in Austin, San Antonio and Fort Worth with a total of 284 attendees.

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

Update: Through August 2006, NBS distributed 181,587 brochures and 2,088 posters. There were 476,410 visits to the NBS website. NBS contacted 1,911 Texas OB/GYNS offering NBS brochures for their patients and 179 responded requesting a total of 29,715 brochures. NBS created a compilation of articles from previous issues of the Texas Congenital Adrenal Hyperplasia (CAH) Newsletter and published The Best of the CAHOOT 1995-2003. NBS prepared a Local Health Department Directory for NBS case managers to assist parents in identifying resources to perform the 2nd newborn screen. NBS assisted with the promotion of the PKU Walk of Houston and the Annual CamPHEVER (PKU Camp) in Dallas.

Performance Assessment: Between 2003 and 2006, NBS met the annual objectives with 100% follow-up and case management of identified presumptive positives through increased awareness of the legal requirements for newborn screening and continued technical assistance to minimize the number of unsatisfactory tests submitted.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational			X	

materials on specimen collection and handling procedures.				
2. Educate parents, including expectant parents and parents of newborn children, and health professionals about newborn screening benefit, state requirements, and importance of follow-up to positive tests.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: There were 195,804 specimens collected thus far in FY07 with 4,284 unsatisfactory specimens (2.1%). There have been 114 contacts made with providers and educational materials were distributed. In December 2006, Texas expanded the newborn screening panel to 27 disorders.

NBS hired an educator to provide on-site training for providers. The Texas NBS Program provided on-site in-service education on a monthly basis in locations throughout Texas from September 2006 through January 2007. In collaboration with the state laboratory EPSDT program, specimen collection training was provided in Tyler and Lubbock.

Activity 2: Educational materials distributed included brochures (111,597), posters (411), and website visits (238,561). NBS contacted over 4,000 health professionals through newsletters and special postcards in preparation for the expansion of the newborn screening panel and to promote the new parent education brochures. Direct mailings were also initiated to 150 midwives and 330 birthing hospitals.

The NBS Program Medical Consultant provided presentations to Pediatric Grand Rounds at Medical City Dallas, the Texas Medical Association, the Texas Association of Family Practitioners 2006 Primary Care Summit in Houston, and the DSHS Perspectives in Health Conference in Austin. Parents of thirteen year old females with PKU were contacted by DSHS staff to alert them to the dangers and appropriate treatment of girls with PKU that is required during pregnancy.

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

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

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

Activity 2: Educate parents, including expectant parents and parents of newborn children, and health professionals about newborn screening benefit, state requirements, and importance of follow-up to positive tests by distributing brochures on newborn screening to health care providers, providing Information for Parents of Newborn Children pamphlets for distribution by

health care providers and facilities to all expectant and postpartum parents, placing information regarding newborn screening on the NBS Program website, and making an email address available for any questions regarding newborn screening.

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

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

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	57	57.1	57.2	57.3	57.4
Annual Indicator	57.0	57.0	57.0	57.0	57.0
Numerator	142384	142384	142384	142384	142384
Denominator	249840	249840	249840	249840	249840
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	57.5	57.6	57.7	57.8	57.9

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

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments
Activity 1: Support and develop formal and informal mechanisms for partnering in decision-making with families of CSHCN and promoting family networking.

Update: With State agency consolidation decreasing the number of advisory committees, the CSHCN Services Program (SP) continues to implement alternate methods to obtain and document family and stakeholder input.

CSHCN SP staff and contractors participated with families and other stakeholders in many state-level and community-level forums. Family and other stakeholder input is gathered through user-friendly Stakeholder Meeting Records detailing topics and stakeholder recommendations. Several CSHCN SP contractors' advisory committees also provide stakeholder input and recommendations regarding access to care, waiting and interest lists for services, and eligibility

requirements for health and human services in the state.

During FY06, CSHCN SP staff reported input from approximately 115 stakeholder meetings and events attended by nearly 4,700 participants, including 900 family members of CSHCN. CSHCN SP contractors reported input from over 430 stakeholder meetings and events attended by over 17,500 participants, including over 3,800 family members of CSHCN.

Several stakeholder forums reflected concerns regarding six-month re-enrollment requirements for Medicaid, CHIP, and CSHCN SP health care benefits, waiting lists preventing children from receiving needed care, and lack of available care for undocumented persons. Several CSHCN SP contractors collaborated with other community organizations to hold annual conferences for families, providing additional opportunities for stakeholder input.

In quarterly conference calls, National Performance Measure 02 and methods to identify and gather family input, concerns, and recommendations were discussed with CSHCN SP regional staff and contractors. The CSHCN SP is identifying and exploring the use of existing listservs to seek and obtain input from families of CSHCN on specific topic areas.

Activity 2: Systematic reporting of consumer satisfaction with CSHCN SP contractor services and with the state service systems in general.

Update: CSHCN SP contractors surveyed families to determine levels of satisfaction with contractor services and to obtain input for recommended program improvements. During FY06, 1,842 families of CSHCN served by CSHCN SP contractors responded to a contractor's satisfaction survey. Families indicated a very high level of satisfaction with contractor services as 99.6% of families who responded to a survey indicated satisfaction on 75% or more of survey questions.

The CSHCN SP gathered and analyzed contractors' satisfaction surveys to identify common elements. Surveys included questions regarding general satisfaction, telephone and staff contact/customer service, and specific or unique contractor services. CSHCN SP staff will provide technical assistance for contractors in developing and implementing effective client/family satisfaction tools and processes.

Performance Assessment: The 2001 National Survey of CSHCN reported that 57% of Texas families of CSHCN aged 0-18 responded that they are partners in decision-making and are satisfied with the services they receive. Changes in this measure cannot be determined until data from the 2005-2006 National Survey of CSHCN are available. Client/family surveys which were conducted in Texas by DSHS contractors in FY06 consistently reported high levels of satisfaction with case management, clinical services, and family supports or community resource services provided through CSHCN SP community-based contractors.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support and enhance mechanisms for partnering in decision-making with families of CSHCN and promoting family networking.				X
2. Monitor consumer satisfaction with CSHCN Services Program (CSHCN SP) contractor services.				X
3. Assess consumer satisfaction with CSHCN SP health care benefits and with state service systems in general.				X
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: CSHCN SP staff and contractors participate in various advisory groups and receive family and other stakeholder input through these and other forums. During the first half of FY07, CSHCN SP staff reported input from 21 meetings attended by 1,162 participants, including 336 family members. CSHCN SP contractors reported input from 173 meetings attended by 4,876 participants, including 1,815 family members. Key concerns of stakeholders are: six-month re-enrollment for Medicaid, CHIP and CSHCN SP health care benefits, wait lists for children to receive needed care, the lack of available care for the undocumented and in rural areas. Staff identified 10 listservs to monitor and submit questions for stakeholder input. Staff surveyed CSHCN SP contractors regarding their contact with families by email. Email may be a mechanism for periodic input from families.

Activity 2: Of 622 families,98% indicated satisfaction on 75% or more of survey questions. Responses gauged satisfaction and suggested ways to improve services and outreach efforts.

Activity 3: Satisfaction plan implementation began. Steps include setting up a web-based survey process; developing "core" questions for contractors' surveys; adding surveys via the CSHCN SP information line; and studying feasibility for application form inserts. The CSHCN SP surveyed program clients about their medical home and 66% said that their provider implemented 8 or more of 14 medical home features.

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

Output Measures: Monitor and/or update CSHCN/family listservs, contractor advisory groups; stakeholder meeting records; contractor quarterly reports, participation in listservs and report on responses; and develop action plan based on specific input from families.

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

Activity 2: Monitor consumer satisfaction with CSHCN SP contractor services.

Output Measures: Indicators of level of satisfaction with CSHCN SP contractor services; contractor quarterly reports regarding satisfaction survey results and the percentage of their clients who are satisfied with core topic areas as well as other services they receive through the contractor; recommendations or input from consumers; and contractor response to consumer feedback; and contractor quarterly reports of input from consumers and contractor response.

Monitoring: Review of contractor quarterly reports.

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

Output Measures: Consumer satisfaction assessment plan maintained; satisfaction data gathered and analyzed; and recommendations made/actions taken based on results; stakeholder meeting

records; and contractor quarterly reports.

Monitoring: Documentation of the plan progress, barriers, and results.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	58.3	58.4	58.5	58.6	58.7
Annual Indicator	58.3	58.3	58.3	58.3	58.3
Numerator	399631	399631	399631	399631	399631
Denominator	685206	685206	685206	685206	685206
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	58.8	58.9	59	59.1	59.1

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

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments
Activity 1: Engage in the Medical Home Learning Collaborative (MHLC) with three medical practices and a state-level team to learn about, demonstrate, and spread medical homes in Texas.

Update: Texas participated in the Medical Home Learning Collaborative (MHLC) sponsored by the Maternal and Child Health Bureau (MCHB) in 2005. Results confirmed the collaborative learning model as an effective strategy for implementing medical home services in pediatric practices. The Texas State team facilitated improvements at the practice level and incorporated planning for additional medical home activities in the Texas Medical Home Work Group (MHWG) strategic plan. Parent partners in MHLC served as change agents at the practice and state level. Two Texas practices, Baylor College of Medicine Transitional Clinic and Su Clinica Familiar (FQHC), showed substantial improvements in all six medical home domains. Two Texas health plans, Texas Children's Health Plan in Houston and Parkland Kids First Plan in Dallas participated in national medical home research.

Activity 2: Collaborate with others to develop and disseminate a family medical home tool kit to

assist families in expanding the medical home services available from their primary care physicians.

Update: The Family Toolkit developed by Texas Parent to Parent with input from the MHWG and a companion checklist for professionals developed by New England SERVE were disseminated through conferences, trainings, and websites. (The Family Toolkit is included in an attachment to this subsection.) The checklist for professionals and other medical home resources were offered on the CSHCN Services Program (SP) website at the following address: www.dshs.state.tx.us/cshcn/medhome.shtm.

Activity 3: Provide leadership to, and collaborate with members of the MHWG to increase awareness and knowledge of medical homes among all relevant audiences.

Update: The MHWG, facilitated by CSHCN SP staff, added new members, including family physicians, Federally Qualified Health Center staff, and Medicaid/CHIP Managed Care Organizations Medical Directors and/or their staff. The MHWG strategic plan provided the core elements of the medical home module of the Texas Early Childhood Comprehensive Systems plan and provides a structure for statewide medical home activities and progress monitoring. Texas Medicaid and CSHCN SP developed a clinician directed care coordination policy to include reimbursement for non face-to-face care coordination services. Policy adoption is pending fiscal analysis. The Department of Family and Protective Services (DFPS) Request for Proposal for a contracted provider plan to provide healthcare services for children in foster care included medical home components. MHWG members presented information on medical homes at the Texas Parent to Parent Annual Conference.

Activity 4: CSHCN SP regional staff and contractors work to help CSHCN link to and develop medical homes.

Update: During FY06, approximately 80% of CSHCN requesting case management from CSHCN SP regional staff and contractors had a primary care provider (PCP). CSHCN SP regional staff and contractors assisted 2,076 CSHCN in obtaining a PCP, including those affected by Hurricanes Katrina and Rita.

Performance Assessment: The 2001 National Survey of CSHCN reported that 58.3% of Texas CSHCN aged 0-18 received coordinated, ongoing, comprehensive care within a medical home. Changes in this measure cannot be determined until data from the 2005-2006 National Survey of CSHCN are available. Energy and momentum continue to build in increasing awareness of the medical home concept for families, primary care practitioners, third party payors, state agency personnel, and other stakeholders.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide leadership to, and collaborate with members of the Medical Home Workgroup (MHWG) to increase awareness and knowledge of the medical home concept and practice and to promote medical home services and quality improvements.				X
2. CSHCN SP regional staff and contractors help CSHCN link to medical homes.		X		
3.				
4.				
5.				
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b. Current Activities
Activity 1: The Medical Home Workgroup (MHWG) met quarterly to implement the strategic plan. Members are active in the Texas Early Childhood Comprehensive Systems Initiative (Raising Texas) Access to Insurance and Medical Home Workgroup and in a cross-agency quality assessment effort related to CSHCN. Members partnered with THSteps to develop an online medical home training module for physicians and other health care providers. Members participated in the Center for Medical Home Improvement research project. The Texas Association of Community Health Centers (TACHC) distributed medical home quality improvement information to FQHCs. TXP2P distributed 400 Medical Home Family Toolkits. The CSHCN SP sent a booklet, "Emergency and Disaster Planning for CSHCN", to CSHCN SP health care benefits clients. A survey sent with the booklet asked families about their experiences with the doctor or nurse that their child sees the most related to 14 medical home characteristics. A total of 66% of respondents noted that their doctors or nurses implemented more than half of these characteristics. Of the responders, 20% noted that their doctors or nurses implemented 5 or fewer of the 14 characteristics to rank "low" or "very low" on a scale of "medical homeness."

Activity 2: During the first half of FY07, 87% of CSHCN receiving case management and clinical services from CSHCN SP regional staff and contractors had a primary care provider (PCP). Almost 500 CSHCN were assisted in obtaining a PCP.

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

Output Measures: Progress on the MHWG strategic plan; MHWG minutes; information received from other sources; articles published in the provider Bulletin and Family Newsletter; presentation schedule (conferences, seminars, and other venues); website postings to primary websites - CSHCN Services Program website and Texas page of AAP medical home website, and other relevant websites; and development and dissemination of materials/tools information.

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

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

Output Measures: Number and percent of CSHCN served by regional staff and case management/clinical services contractors with a primary care physician as reported in regional activity report and contractor quarterly reports; number of CSHCN assisted with linking to a primary care physician by regional staff and case management/clinical services contractors as reported in regional activity report and contractor quarterly reports.

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	52.9	52.9	52.9	52.9	54
Annual Indicator	52.9	52.9	52.9	52.9	52.9
Numerator	366173	366173	366173	366173	366173
Denominator	692198	692198	692198	692198	692198
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	54.1	54.2	54.3	54.4	54.5

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

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments
Activity 1: Pursue opportunities with employers, private sector insurance providers, and the Texas Department of Insurance to enhance benefits for families of CSHCN.

Update: There were limited opportunities to meet with employers, private sector insurance providers, and the Department of Insurance regarding benefits for families of CSHCN during FY06. CSHCN SP contractors participated in community health fairs to provide information on benefits for families of CSHCN. Several CSHCN SP contractors are also active participants in Medicaid Managed Care Regional Advisory Committees which provide an opportunity for input into the Texas Medicaid managed care programs and to assist in devising local solutions to issues or problems.

Activity 2: Provide information on public and private health insurance to families of CSHCN.

Update: CSHCN Services Program (CSHCN SP) regional staff/contractors helped CSHCN/families with CHIP/Medicaid/CSHCN SP enrollment/renewals to prevent lapses in coverage. They assisted families of CSHCN in keeping private insurance, if available. They participated in health fairs/other events to give out information on program benefits. The CSHCN SP website and Family Newsletter shared information on CSHCN SP waiting list releases.

Activity 3: Expand the number of providers serving CSHCN SP health care benefits clients.

Update: As of August 31, 2006, Texas Medicaid and Healthcare Partnership (TMHP) noted 4,575 CSHCN SP providers were enrolled. Since June 2004, 2,176 new providers were enrolled, including 1,147 pediatricians and 557 family physicians. TMHP conducted 12 "Success with CSHCN" provider workshops across the state in July 2006.

Activity 4: Payment of insurance premiums for clients on the CSHCN SP to help families maintain cost effective private insurance.

Update: Sixty-nine (69) clients received insurance premium payment assistance paid by CSHCN SP in FY06.

Activity 5: Provide CSHCN SP health care benefits to eligible individuals.

Update: CSHCN SP case management regional staff and contractors worked with families of CSHCN to ensure that all available health care funding sources were accessed. Families were provided regular reminders and assistance with application renewal deadlines. During FY06, 2,101 clients received CSHCN SP health care benefits. A waiting list for CSHCN SP health care benefits existed due to funding limitations.

Activity 6: Monitor CSHCN SP health care benefits clients on the waiting list.

Update: A total of 852 clients were released from the CSHCN SP waiting list during FY06. As of 8/31/06, 1,276 clients remained on the CSHCN SP waiting list, 581 (46%) of whom had no other third party coverage for health care benefits. Movement from the CSHCN SP waiting list for health care benefits is contingent on available funds.

Performance Assessment: The 2001 National Survey of CSHCN indicated that 52.9% of families of CSHCN aged 0-18 reported that they have adequate private and/or public insurance to pay for the services they need. Changes in this measure cannot be determined until data from the 2005-2006 National Survey of CSHCN are available. The number of CSHCN provided health care benefits through CSHCN SP increased by 14% in FY06 as compared to FY05.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Pursue opportunities to collaborate with Texas Medicaid, CHIP, and other public/private health benefits providers and agencies to maximize health care coverage and quality assurance parameters of such coverage for CSHCN.				X
2. Maximize provision of CSHCN SP health care benefits to eligible clients through continued provision of benefits; increased providers serving CSHCN SP health benefits clients; payments of insurance premiums; and monitoring waiting list.	X	X	X	X
3. Explore opportunities to enhance information shared with employers regarding the benefits and supports needed by employees who are parents of children with disabilities as well as the benefits and supports needed by employees with disabilities.				X
4. Provide information on public and private health insurance and health care financing for CSHCN to families of CSHCN and providers.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The Health and Human Services Commission (HHSC) awarded funding to 21 community-based organizations to help families enroll in CHIP, Medicaid, and other services. The Children's Policy Council recommended that Texas develop a Medicaid Buy-In option for children with disabilities. The Consumer Directed Services Workgroup recommended expansion of this service option to other programs.

Activity 2: During the first half of FY07, 143 children were released from the waiting list for CSHCN SP health care benefits. Due to funding limitations, over 1,100 children were on the waiting list for health care benefits as of 2/28/07. Of these children, 36% had no other health care coverage. The CSHCN SP assisted 48 families with insurance premium payment.

Activity 3: No activities during September 2006 thru February 2007.

Activity 4: The CSHCN SP Client Handbook, available in English and Spanish, was revised and disseminated through websites and print copies. The Family Newsletter included information on application for CSHCN SP health care benefits and Medicaid. Information was sent to families and providers regarding special needs trust administration, school-based Medicaid, Medicaid buy-in, and other topics. CSHCN SP contractors participate in health fairs, coalitions and other meetings to provide information on benefits for families of CSHCN.

c. Plan for the Coming Year

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

Output Measures: Documentation of collaborative initiatives/efforts with health care benefits providers and regulating agencies, e.g. collaboration with Medicaid to expand incentives for Medicaid providers to provide more comprehensive medical home services, and the results of those efforts.

Monitoring: Review documentation of progress made on collaborative efforts.

Activity 2: Maximize the provision of CSHCN SP health care benefits to eligible clients by providing benefits to eligible clients; increasing the number of CSHCN SP providers; paying insurance premiums for clients on the CSHCN SP within program guidelines; and monitoring clients on the waiting list for health care benefits.

Output Measure(s): Number of ongoing CSHCN SP health care benefits clients in different population categories by age and the number that receives health care benefits; increase in number of providers serving CSHCN SP health benefits clients; number of CSHCN SP clients receiving insurance assistance; number of clients on the waiting list by age with and without insurance; and number of clients removed from the waiting list by age.

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

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

Output Measures: Documentation of activities; information shared with employers; feedback from employers. Documentation of materials developed, meetings, training.

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

meetings.

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

Output Measures: Articles published in Family Newsletter and Provider Bulletins, including related legislation, Medicaid Buy-In, websites (including SSA); information for 211 operators; information posted on CSHCN Services Program website; and informational materials shared via staff, contractors, or other means.

Monitoring: Review of quarterly reports; agency action for implementing bill; articles published.

Activity 5: Coordinate with Medicaid and CHIP to provide information for publication in their provider/family publications.

Output Measure: Articles published in family and provider publications on CSHCN.

Monitoring: Review of articles appearing in CHIP/Medicaid publication.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	76.8	76.9	77	77.1	77.2
Annual Indicator	76.8	76.8	76.8	76.8	76.8
Numerator	193670	193670	193670	193670	193670
Denominator	252253	252253	252253	252253	252253
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	77.3	77.4	77.5	77.6	77.6

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

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

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

Update: The Health and Human Services Commission (HHSC) reported 103,130 Maternal Child Health-related 2-1-1 calls during FY 06. For issues specific to CSHCN, the majority of referrals were related to disease-specific screening and diagnosis and specialized treatment, assistive technology, and attendant care or respite care.

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

Update: CSHCN SP staff and contractors participated in numerous committees to assess and improve state policies and programs for CSHCN, including the Children's Policy Council, Promoting Independence Committee, TX Integrated Funding Initiative, Texas Council for Developmental Disabilities, Traumatic Brain Injury Advisory Council, and Medical Home Workgroup. Staff lent expertise and energy in addressing topics such as medical home, transition, and permanency planning.

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

Update: The CSHCN SP Benefits Hotline is staffed by bilingual staff. CSHCN SP consumer publications in English/Spanish included client applications and correspondence, the "medical home" brochure, "transition" letter, and the quarterly Family Newsletter. CSHCN SP contractors were informed of the MCH Cultural Competency online resources. Several contractors translated forms, service plans, and assessments into Spanish. CSHCN SP hired a bilingual publications specialist to assist in translating publications and other written content.

Activity 4: Provide CSHCN case management through CSHCN SP.

Update: During FY06, 14,569 families of CSHCN received case management services through CSHCN SP regional staff and contractors. Staff and contractors participated in health fairs and trainings on local services and resources, and worked with local churches and other organizations to support CSHCN & families displaced by Hurricanes Katrina and Rita. Regional staff and contractors assist CSHCN and their families in planning for future emergencies. Contractors partnered with other community organizations to offer numerous trainings and workshops for parents.

The CSHCN SP website recorded 92,846 hits in FY06, more than doubling the number of hits in FY05. The Transition page added many new links with helpful information for youth and families. The CSHCN Family Newsletter included articles on transition for CSHCN, easy-to-access information on finding a case manager or social worker, Early Childhood Intervention resources, and summer camps. The CSHCN SP developed a bilingual emergency preparedness publication and online information for families of CSHCN.

Performance Assessment: The 2001 National Survey of CSHCN indicated that 76.8% of families of CSHCN aged 0-18 reported that community-based services are organized so they can use them easily. Changes in this measure cannot be determined until data from the 2005-2006 National Survey of CSHCN are available. Participation by staff in systems change arenas and extensive involvement of contractor staff continue to help improve the community-based services system.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Participate in DSHS collaboration with Texas Information and Referral/2-1-1 system to foster effective linking of CSHCN and their families to community services and supports.				X
2. Participate in interagency and intra-agency efforts to assess and improve state policies and programs that impact CSHCN and their families.				X
3. Continue and enhance use of appropriate languages and cultural approaches in publications and other interactions with CSHCN SP consumers.			X	
4. Provide CSHCN case management through CSHCN SP.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: For the first half of FY07, there were 61,819 MCH-related calls to the 2-1-1 system. Title V and 2-1-1 staff discussed revisions to 2-1-1 data collection to provide more specific information in FY08.

Activity 2: CSHCN SP staff and contractors documented participation in 194 stakeholder meetings to assess and recommend improvements in policies and services for CSHCN. The Children's Policy Council Report to the Legislature recommended the development of a coordinated independent case management system. In response to SB1188, the HHSC awarded Navigant Consulting a contract to study optimization of case management services. Draft results and recommendations are being shared with stakeholders in July 2007. The CSHCN SP shared information to help orient the contractor and assisted in gathering data.

Activity 3: The CSHCN SP published a bilingual booklet to assist families of CSHCN in preparing for a disaster or emergency. The October CSHCN Family Newsletter included a bilingual Emergency Information Form. The CSHCN Family Newsletters, available in English and Spanish, are mailed to program clients and are also available on the CSHCN SP web site. The CSHCN SP requested examples of contractor materials in languages other than English to assist with proficiency of translations.

Activity 4: In the first half of FY07, 8,913 CSHCN received case management from CSHCN SP contractors and DSHS regional staff.

c. Plan for the Coming Year
National Performance Measure 05: Percent of Children with Special Health Care Needs age 0-18 whose families report the community-based systems are organized so they can use them easily.

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

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

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

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

Output Measures: Documentation of relevant groups in which CSHCN SP staff participate actively; review of Stakeholder Meeting Records and identification of recommendations, policy, and program changes impacting CSHCN (twice yearly discussion within Systems Development group); contractors report of discussion, recommendations, or actions at committee/agency meetings related to performance measure; and contractor quarterly reports.

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

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

Output Measures: Bilingual publications and Spanish language content on CSHCN SP website; publications, website postings, etc.; CSHCN SP staff/contractor training/discussions of experiences and lessons learned (informal and formal) with regard to cultural competency, contractor quarterly reports; emails/information shared with contractors and staff; and Internal / External Cultural Competency plan implemented.

Monitoring: Review of communications products, staff activities, contractor training, technical assistance, and/or discussions, and contractor quarterly reports.

Activity 4: Provide CSHCN case management through CSHCN SP.

Output Measure(s): Number of CSHCN receiving case management from CSHCN SP contractors and regional staff; contractor quarterly reports, quarterly regional activity reports.

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

Activity 5: Enhance communication among CSHCN SP Contractors.

Output Measure: Hits on web log, postings on bulletin board, calendar of events; newsletters sent, and discussion of contractor activities/successes during contractor conference calls.

Monitoring: Review of web log, reports of collaborations, contacts, contractor conference calls minutes.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					5.8
Annual Indicator	5.8	5.8	5.8	5.8	5.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5.8	5.8	5.8	5.8	5.8

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

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

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.
Since Texas does not have state-specific data or projections at this time, the 2001 and 2002 national average data should be inserted, if needed, for the 2003-2009 projections."

a. Last Year's Accomplishments
Activity 1: Provide transition planning and referrals for Children with Special Health Care Needs Services Program (CSHCN SP) clients through CSHCN SP case management services provided by regional staff and contractors.

Update: During FY06, regional staff and contractors assisted 1,139 youth with transition planning and referral. Staff updated web resources and developed bilingual standardized correspondence and resources. Staff developed online case management transition training content and did beta testing.

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

Update: Program contractors sponsored workshops and developed surveys, handbooks or reference tools, and a peer mentoring project. They attended local transition coalitions, hired a transition specialist, and created strategic plans. Program staff and family members did presentations on Transition at the 2nd Annual Texas Parent to Parent Conference.

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

Update: Staff and CSHCN SP contractors throughout the state began recruiting adult mentors through internal and external contacts.

Activity 4: Lead DSHS Transition Work Group to advise the CSHCN SP and help achieve Title V CSHCN objectives for transition to adult health care services, including dissemination of information to CSHCN, families, providers, and other stakeholders.

Update: The work group met bi-monthly and planned and developed transition materials, including standardized checklists, resource lists, and letters for case managers and families.

Activity 5: Collaborate with other state agencies, the Texas Leadership Education in Adolescent Health (LEAH), and other transition programs by serving on boards, helping plan transition content of conferences, and sharing information on transition planning and promising practices.

Update: Staff and contractors attended the LEAH 2005 Conference, interagency meetings, the 2006 LEAH Conference planning committee, and the Texas Education Agency Area II Education Service Center conference in February 2006.

Activity 6: Participate in the update and adoption by rule of a Memorandum of Understanding (MOU) among state agencies, including at least, the Texas Education Agency, the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS) and DSHS, regarding transition services for students enrolled in special education programs.

Update: The 79th Texas Legislature (2005) did not enact law for a transition MOU; therefore, no MOU will be executed during the FY06-FY07 biennium. Staff participated in an interagency work group sponsored by DARS to improve community support for transition.

Performance Assessment: National survey data is not available. Work is ongoing to improve the effectiveness of case management support of transition from pediatric to adult health care service systems, to offer more information and training opportunities for families and case managers, and to participate in state-level arenas addressing transition to adult health care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide transition planning and referrals for Children with Special Health Care Needs Services Program (CSHCN SP) clients through CSHCN SP case management services provided by regional staff and contractors.		X		
2. Work with selected contractors to provide transition services and report on best and promising practices.				X
3. Develop a mentoring initiative through which adults with special health care needs mentor transitioning youth with special health care needs.				X
4. Recruit Transition Partners, including youth and adults with special health care needs, to advise the CSHCN SP about transition activities.				X
5. Lead Purchased Health Services Unit staff Transition Team to coordinate CSHCN SP transition activities.				X
6. Collaborate with other entities to share information on transition planning and promising practices.				X
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Regional staff/contractors provided transition planning for 667 CSHCN through this reporting period. CSHCN SP staff updated and translated web pages, wrote newsletter articles and permanency planning correspondence; went to statewide conference, and sent 21 resource emails. Online transition training began in the fall of 2006 with 44 trained to date, including staff/contractors. Training can be accessed for free on the web at www.centerforhealthtraining.org/dshstt/index.html.

Activity 2: Contractors reported in conference calls and provided services via brochures, community workshops, high school/student interaction, parent/family future planning, and health provider access problem solving.

Activity 3: CSHCN SP staff continue trying to recruit adults and began a feasibility study, but have

been unable to recruit enough adults or gain statewide momentum. A few local groups exist. Staff will study and report feasibility of continuing this activity.

Activity 4: CSHCN SP staff contacted the Developmental Disabilities Council Youth Leadership and Advocacy Project leaders and began planning for future collaborations.

Activity 5: Bi-monthly meetings provided direction for program operations.

Activity 6: Staff/contractors took part in the 2006 LEAH Conference and in 2007 conference planning. Staff took part in Texas AHEAD Conference, inter-agency meetings, and writing Children's Policy Council recommendations for the Texas legislature regarding CSHCN issues.

c. Plan for the Coming Year

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

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

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

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

Output Measures: Contacts with contractors to discuss transition activities and provide support/technical assistance; and contractor quarterly reports, conference calls, and review of information exchanged, including identification and reporting of successful practices.

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

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

Output Measures: Number of youth, adult, and family advisors identified and input/guidance received on transition activities.

Monitoring: Review of progress reports.

Activity 4: Lead Purchased Health Services Unit (PHSU) Transition Team to coordinate CSHCN SP transition activities.

Output Measure: Progress reports of Transition Team activities, products, and results.

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

Activity 5: Share resources and collaborate on transition planning and promising practices.

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

Monitoring: Review of meeting minutes, stakeholder meeting records, and reports of other collaboration efforts.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	80	80	80	80	80
Annual Indicator	70.9	77.2	72.5	78.4	79.2
Numerator	358701				
Denominator	505925				
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	80	80	80	80

Notes - 2006
Source for these data is the National Immunization Survey. Data for 2006 not available at the time of submission. Indicator is a linear estimate based on data from 2002 through 2005.

Notes - 2005
Source for these data is the National Immunization Survey - 2005.

Notes - 2004
Source of the data is the National Immunization Survey (NIS). NIS is a sample survey. Therefore, numerator and denominator data are not available. Data are abstracted from NIS reports (http://www.cdc.gov/nip/coverage/default.htm#chart).

Note: 2004 data has been updated to include the hepatitis B vaccine in the set of immunizations.

a. Last Year's Accomplishments
Activity 1: Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.

Update: The Texas Immunization Stakeholders Working Group (TISWG) entered its third year of collaboration. The membership has increased from 13 core members to 19 with the inclusion of representatives from various pharmaceutical partners and subject matter experts. Generally, there were 30 members in attendance at each meeting, some traveling from across the state to participate. We have maintained the initial core members on a voluntary basis and it is significant to note having done so without funds for travel or meal reimbursement. TISWG met on February 16, 2006, June 1, 2006 and August 17, 2006.

During state fiscal year 2006, TISWG focused on those items previously identified as the top priorities for the Immunization Branch of the DSHS. These priorities were: promoting adolescent

immunization, increasing 4th DTaP coverage, and promoting education and marketing of the state immunization registry, ImmTrac. Members divided into three sub-workgroups and worked diligently to provide detailed recommendations for the DSHS to address. In addition to the final recommendations, members provided suggestions regarding education of media, general public, and providers and strengthening partnerships with both the Texas Association of Obstetricians and Gynecologists and the Texas Association of Family Physicians. The results of TISWG recommendations led directly to the Immunization Branch 2007 action plan to respond to the three priority issues identified.

DSHS staff continued to work with both internal and external stakeholders including representatives from WIC, the Texas Health Steps Program, and the Medical Home Workgroup building partnerships and obtaining feedback. Agency and Division publications acknowledged the success and accomplishments of the TISWG during the year. The acknowledgement of TISWG's progress and reaching another anniversary was published in both HHSC and DSHS publications, The Connection and The UpShot respectively. Also a description of the development and achievements of TISWG was presented at the 7th National Conference of Immunization Coalitions held August 9-11, 2006.

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

Update: Statewide, 309,976 children who were under the age of six (6) as of August were added to ImmTrac during the period of 9/1/05 thru 8/31/06.

Performance Assessment: Projections suggest that in 2007 Texas will meet the annual objective of 80% immunization. Continued activities include, but are not limited to, statewide distribution of vaccines, promotion of ImmTrac registration, well-checks provided through Title V contractors, provision of training and technical assistance, and the development and support of partnerships that can educate providers and promote adherence to immunization schedules in local areas.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.				X
2. Through provider and birth registrar education, training and technical assistance, promote the use of the state immunization registry, ImmTrac.			X	
3. Identify birth and delivery characteristics that are associated with not being immunized.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The Texas Stakeholders Immunization Working Group is a statewide collaboration entering its third year. Between 9/1/06 through 2/28/07, the following new members were added to the working group: Adult and Adolescent Immunization Coordinator and the Infectious Disease Control Unit. Membership changes reflecting turnovers in the pharmaceutical representatives and

internal DSHS staff programs have been quickly replaced. The partnership goal to raise vaccination coverage levels across the state through promotion of nationally known best practices continues. In review of our local health department affiliates, 27 of the 50 indicated successful partnership development and best practice implementation.

Activity 2: Between 9/1/06 and 2/28/07, 190,209 children who were under age 6 as of 2/28/07 were added to ImmTrac.

Activity 3: This activity requires data linkages between immunization and the birth record. In the first half of FY07, the SSDI Governance Committee was established to facilitate data linkages. Title V staff are pursuing these data matches in order to complete the analysis in the second half of FY07.

c. Plan for the Coming Year

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

Output Measure: Number and types of partnerships; summary report on efforts undertaken.

Monitoring: Track the number and type of partnership activities.

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

Output Measure: Number of children under six who participate in the state immunization registry, ImmTrac.

Monitoring: Track number of new children entered into the ImmTrac system.

Activity 3: Explore opportunities to link existing administrative data sets within DSHS and across HHSC and other state agencies.

Output Measure(s): Number of data matches, number of agencies involved.

Monitoring: Minutes from monthly SSDI Governance Committee meetings.

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

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	50	50	50	37	37
Annual Indicator	38.9	37.0	37.9	38.3	37.4
Numerator	18722	18271	18588	19183	19108
Denominator	481349	493945	490212	500489	510451
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	37	37	37	37	37

Notes - 2006
Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

Notes - 2005
Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

Population data for Texas are provided by the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

Notes - 2004
Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

a. Last Year's Accomplishments
Activity 1: Make available funds through competitive Request for Proposals (RFPs) for the provision of family planning services statewide.

Update: Fifty-four (54) Title V-funded contractors, 51 Title X-funded contractors, and 68 Title XX-funded contractors (83 unduplicated contractors) provided family planning services. The total number of teens ages 15-17 receiving these services for this time period was 15,898 (15,332 females and 566 males).

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

Update: Through August 2006, the Abstinence Education Program (AEP) served a total of 492,394 unduplicated clients. Of these served, 68% were 19 years of age or less, 1% were 20 to 24 years of age, and 31%, were over 24 years of age. The program was delivered by 36 community-based contractors and 19 Education Service Centers. During FY06, additional funds were awarded to contractors to expand some youth programs and to provide parent programs.

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

Update: DSHS identified 25 counties of greatest need for programs to reduce teen pregnancy and repeat teen pregnancy. A competitive request for proposals (RFP) released in October 2005, resulted in funding for four three-year teen pregnancy prevention projects. In Harris County, two evidenced-based curriculums, "Reducing the Risk" and "Becoming a Responsible Teen" were implemented. Both include components to improve teen access to family planning services. The Potter County program uses "Futures Orientation" that has components for abstinence, mentoring, career preparation, and community service. The El Paso County program focuses on improved communication skills to prevent teen pregnancy and sexually transmitted disease and has convened stakeholders for input to select a culturally competent curriculum. The contracts started on January 1, 2006, and ended on August 31, 2006. A continuation RFP was released in

the spring of 2006 and all four projects were funded for the second year. A second competitive RFP released in the spring of 2006 resulted in the addition of three new teen pregnancy prevention projects beginning September 1, 2006.

Activity 4: Provide information to increase awareness of teen pregnancy rates of health disparity in Hispanic and African American teens.

Update: Through August 2006, information related to health disparities in teen pregnancy was posted on several DSHS websites, which are fully accessible to the public and well-utilized based on the number of website hits. These include the Center for Health Statistics data (which can be queried), the Health Disparities Task Force Annual Report, 2004, and the DSHS Family Planning webpage, which has a Teen Pregnancy Prevention page and links to the Teen Pregnancy Fact Sheets.

Performance Assessment: While lower than 2004 and 2005, projected adolescent pregnancy rates for 2006 remain higher than the rate of 37.0 births per 1,000 adolescent females. Efforts to reduce adolescent pregnancy will continue to utilize a comprehensive, community-based approach that includes family planning services. In FY08, the Texas Title V program continues to fund seven projects to address adolescent pregnancy in targeted areas with the highest occurrence of adolescent pregnancy and repeat pregnancy. Staff with clinical expertise in physical and mental/emotional health serve as agency wide consultants to ensure that all adolescent needs are met when designing interventions. Texas Title V has also conducted analyses to understand how changing Texas demographics will impact adolescent pregnancy through the next decade. These analyses will be used to engage internal and external stakeholders and develop future strategic initiatives.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Make available funds through competitive RFPs for the provision of family planning services statewide.	X			
2. Provide funding for community-based abstinence projects for adolescents and teenagers.			X	
3. Identify target areas and subpopulations in the state with highest rates of teen pregnancy and repeat teen pregnancies and provide funds through a population based competitive RFP to address teen pregnancy in the targeted areas.			X	
4. Provide information to contractors, regional staff and other stakeholders to increase awareness of teen pregnancy rates, including the disparity in the rates for Hispanic and African American teens.				X
5. Conduct a Perinatal Periods of Risk (PPOR) analysis of most recent available data for Texas.				X
6. Analyze PRAMS unintended pregnancy data and develop a policy paper that includes recommended best practices and interventions for specific populations.				X
7. Explore collaborations with Baylor University School of Medicine, Division of Adolescent Health to develop and test innovative solutions to reduce teen pregnancy.				X
8.				
9.				
10.				

b. Current Activities
Activity 1: Eighty-three DSHS contractors provided family planning services to 9,989 teens ages 15-17, of which 9,610 were female and 379 were male.

Activity 2: The AEP served a total of 145,531 unduplicated clients from September '07 through February '07. For FY07, 38 community-based contractors and 20 School Health Education Service Centers provided abstinence education services.

Activity 3: A competitive RFP released in October 2005, resulted in four three-year teen pregnancy prevention projects. In spring 2006, all four projects were renewed with three additional teen pregnancy prevention projects funded. All are beng monitored by Title V staff.

Activity 4: Information related to health disparities in teen pregnancy is posted on several DSHS websites. All Family Planning contractors are required to do community education.

Activity 5: Data from 1999 through 2003 were analyzed using the PPOR analytic framework. Findings were presented at various locations around the state. Presentation handout is attached.

Activity 6: Analysis of pregnancy timing has been completed. Findings have been presented to the March of Dimes' Program Services Committee included the benefits of folic acid and preconception health, and impact of stress in African-American pregnacies. Presentation handout is attached.

Activity 7: Baylor University School of Medicine, Division of Adolescent Health and Title V have met, and DSHS Adolescent Health and Child Health Coordinators attended several LEAH events.

c. Plan for the Coming Year
Activity 1: Make available funds through continuation request for proposals (RFPs) for the provision of family planning services statewide.

Output Measures: Number of Title V contractors, number of Title X contractors; the number of Title XX contractors; the number of teens receiving family planning services; annual numbers of births averted.

Monitoring: Review contractor reports quarterly for number of clients served, review annual report of numbers of births averted by region.

Activity 2: Identify target areas and subpopulations with highest rates of teen pregnancy and repeat teen pregnancies and provide Title V funds through a population-based RFP to address teen pregnancy in the targeted areas.

Output Measures: Number of target areas of the state with highest rates of teen pregnancy; number of contracts awarded; summary report on project implementation and milestones.

Monitoring: Review contractor work plans quarterly, review summary reports of project implementation and milestones quarterly.

Activity 3: Provide information to contractors, regional staff and other stakeholders to increase awareness of teen pregnancy rates, including the disparity in the rates for Hispanic and African American teens.

Output Measures: Number, type and format of materials provided.

Monitoring: Review of health indicator and outcome data and best practices research

Activity 4: Engage external and internal stakeholders to identify opportunities and innovative interventions to prevent adolescent pregnancy.

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

Monitoring: Review meeting notes; quarterly progress reports.

Activity 5: Analyze PRAMS unintended pregnancy data and develop a policy paper that includes recommended best practices and interventions for specific populations.

Output Measures: Analysis of data sets, including trends; list of recommended best practices and interventions and process for selection; policy paper developed.

Monitoring: Review progress on data analysis and development of policy paper.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	20	21	22	35	35
Annual Indicator	37.5	43.4	54.3	30.8	30.8
Numerator	2687	1550	6468	2807	2807
Denominator	7156	3572	11902	9108	9108
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	35	35	35	35	35

Notes - 2006
The FY06 data is identical to the 2005 data because program staff used 2005 and 2006 to select a randomized sample of third graders from schools with 50% or more free school lunch participation. This sample represents about 70% of the third graders in Texas, but has limited generalizability. In 2007, a new, more sophisticated sample will be drawn. Source, DSHS Statewide Dental Survey. Data reported by the DSHS Oral Health Program.

Notes - 2005
Staff used 2005 and 2006 to select a randomized sample of third graders from schools with 50% or more free school lunch participation. This sample represents about 70% of the third graders in Texas, but has limited generalizability. Source, DSHS Statewide Dental Survey. Data reported by the DSHS Oral Health Program.

Notes - 2004
Despite the FY04 annual indicator, the program has opted to set the target of 35% to reflect the limitation of this measure. The population involved is limited to the reduced/free lunch program.

a. Last Year's Accomplishments

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

Update: During FY06, Basic Screening Survey (BSS) data from 132 schools captured ethnicity, gender, age, Medicaid status, history of existing/past sealants, treatment urgency, early childhood caries, and dental sealants placed. Of the 9,108 third graders screened by the regional oral health staff over the 2005-2006 period, 30.8% either presented with dental sealants or received sealants from regional oral health staff.

Performance Assessment: The trend in this measure has reversed from exceeding performance objectives in 2002 through 2004 to lower than annual performance objectives in 2005 and 2006. In 2006, the percent of third grade students who have received at least one protective sealant was nearly 7 percentage points below the annual performance objective of 35%. In April of 2006, dental services that had been eliminated from the Children's Health Insurance Program during the prior legislative session were restored. That program change, in addition to increased dental rates for Medicaid providers approved in the 80th Texas Legislative Session, should contribute to increased success in this measure.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue providing dental sealants to Texas third grade population statewide.	X			
2. Continue to establish baseline data on the numbers of 3rd graders with untreated caries to gather data to use in guiding programmatic decisions.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: From September 2006 through February 2007, the DSHS regional dental teams provided dental screening services to 1,941 third graders and provided sealants to 747 (38%) third graders who were eligible for the services and had teeth in need of sealants. During this time, DSHS regional dental teams provided 9,147 eligible school children with dental screening services and 3,318 (38%) received dental sealants on at least one tooth. At multiple Head Start sites across the state, 2,433 preschool children were screened and 2,429 (99%) received fluoride varnish treatments. Total number of children served was 11,299 with 5,833 (52%) receiving follow up preventive dental services.

Activity 2: Analysis of BSS data has begun in FY07. These analyses will be used to create baseline measures for 3rd graders with untreated caries. These data have also been used in the preparation of an abstract that explores rural, urban, and border differences in dental caries in Texas. A review of the BSS has yielded several lessons learned which will be used to improve sample selection for future surveillance projects.

c. Plan for the Coming Year

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

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

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

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

Output Measure: Summary of convenience sampling data from regional dentists and other entities.

Monitoring: Analyze, interpret and report on data collected.

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

Output Measure: Summary of service utilization.

Monitoring: Analyze, interpret and report on data collected.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	5.5	5.5	5.5	5.5	5.4
Annual Indicator	5.6	5.4	6.2	5.3	5.2
Numerator	259	259	296	274	276
Denominator	4647317	4752653	4768628	5185439	5284398
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5.1	5	5	4.9	4.9

Notes - 2006
This measure is populated with children ages 1 through 14. Population data for Texas are provided by the Center for Health Statistics, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

Note that 2004 birth and death related data were updated as of 9/17/07 and provisional data for 2005 and 2006 were adjusted based on a projected linear trend of data from 1996 through 2004.

Notes - 2005
Note that 2004 birth and death related data were updated as of 9/17/07 and provisional data for 2005 and 2006 were adjusted based on a projected linear trend of data from 1996 through 2004.

This measure is populated with children ages 1 through 14. Population data for Texas are

provided by the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

Notes - 2004
Source: DSHS Center for Health Statistics, data for this measure was entered in 2007 following the availability of actual data for 2004.

Note that 2004 birth and death related data were updated as of 9/17/07.

a. Last Year's Accomplishments
Activity 1: Provide child passenger safety presentations to children ages 0-8 regarding car seat safety.

Update: Through August 2006, the Safe Riders Traffic Safety Program provided 21 child passenger safety (CPS) presentations to 405 adults and 44 children throughout Texas. Audiences for these presentations included the Austin Police Department and Department of Public Safety, who received detailed instructions regarding the CPS citation card, which Safe Riders created and printed. This card, designed to fit into an officer's citation book, listed both the new Texas occupant protection law and safety recommendations. This ensured that officers know the specifics of the occupant protection law and the best-practice safety recommendations, which exceed the minimum standard of the law. Other presentations included a puppet show with traffic-safety songs to children and their parents at a church festival; presentations to teen parents and to a mother's group. Safe Riders also conducted four CPS technician-training workshops (32-hours each) to 49 nurses, police officers and other professionals. CPS technicians are certified to provide technical assistance to parents for correct use of child seats. Safe Riders conducted three CPS update and renewal classes to 17 existing or former CPS technicians.

Activity 2: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8.

Update: Through August 2006, Safe Riders monitored 74 community partners who served as child restraint distribution sites in Texas (13,678 child restraints were provided to these partners). Safe Riders also provided 2,136 child seats to the following groups: Texas Children's Hospital (Houston), El Paso Safe Communities, Texas Cooperative Extension Service, Hillcrest Hospital (Waco), and Texans in Motion (Austin & surrounding area).

Performance Assessment: The rate of motor vehicle crashes among children 14 years and younger remained constant at 5.5 deaths per 1,000. Between 2002 and 2006, this rate has ranged between 5.0 and 6.2 deaths per 1,000. The projected annual indicator for 2006 is two tenths of a percent lower than the annual performance objective which of 5.4. Future activities need to emphasize continued prevention to lower the number of annual deaths. Increased collaboration between the State Child Fatality Review Team (CFRT), local CFRTs, and the Texas Department of Transportation will help to identify and meet educational needs and prevention opportunities. Texas continues its commitment to provide education and child safety seats throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct traffic safety presentations throughout the state.			X	
2. Distribute car safety seats to low-income families throughout the state and train recipients on the proper use of the seats.			X	
3. Assess the need for training middle school-aged children in the state on the dangers of riding with alcohol-impaired drivers;			X	X

and, if appropriate, select or identify a training module to deliver.				
4. Review of report on child deaths resulting from motor vehicle accidents in the state and develop policy recommendations aimed at reducing such deaths, as appropriate.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: During September 2006 - February 2007, Safe Riders conducted six traffic safety presentations to 55 persons. This included two presentations to teen parents (or parents-to-be), and four presentations to adult audiences: a firefighter's regional conference, a mom's club, a home for low-income mothers, and an association of child care providers.

Activity 2: Safe Riders monitored 76 community programs statewide as they operated a child seat distribution program. To receive a seat, a family or parent is required to attend a one-hour class regarding child passenger safety. Each local program reports monthly to Safe Riders the number of seats that are provided. During the reporting period of September 2006 - February 2007, Safe Riders distribution program partners distributed 3,609 seats in conjunction with education programs. Safe Riders also sent 2,263 child seats to the following five agencies for distribution to low-income families in conjunction with child seat checkup events: Texas Cooperative Extension, Hillcrest Health System (Waco), Dallas County Hospital, Texans in Motion (Austin), and Texas Children's Hospital (Houston).

Activity 3: Staff are exploring data sources and possible curriculum ideas.

Activity 4: During the reporting period, Safe Riders conducted training workshops in Baytown, McAllen, and Marble Falls as these were locations identified during the review of child deaths and injuries from motor vehicle crashes.

c. Plan for the Coming Year
Activity 1: Conduct traffic safety presentations throughout the state.

Output Measure(s): Number of presentations conducted; number of children and adults attending each presentation; and the number and type of educational materials distributed.

Monitoring: Track progress of presentations (per calendar year) as relayed in monthly reports.

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

Output Measure(s): Number of organizations that participate in the distribution and training program; the number of safety seats issued to participating organizations; the number of safety seats distributed; number of local CFRTs receiving trainings on how to conduct child safety seat clinics; number of local CFRTs organizing child safety seat clinics in their local communities; and the number of recipients trained.

Monitoring: Maintain a current list of participating organizations; track the number of seats distributed to the organizations on an ongoing basis; review quarterly reports submitted by participating organizations

Activity 3: Review of report on child deaths resulting from motor vehicle accidents in the state and develop policy recommendations aimed at reducing such deaths, as appropriate.

Output Measure(s): Annual report on child deaths from motor vehicle accidents that includes policy recommendations; development of State CFRT Subcommittee on Prevention to collect local CFRT recommendations and prevention initiatives through quarterly prevention reports.

Monitoring: Updates of child deaths and potential recommendations at quarterly State Committee meetings.

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

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					38
Annual Indicator				37.5	38
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	38.5	39	39.5	40	40.5

Notes - 2006
The percentage for 2006 was estimated based on the final data from 2003 through 2005. TVIS did not allow change in the annual incators for the previous years. The final percentage for the previous years were:
Year 2003 -- 33.8
Year 2004 -- 37.5
Year 2005 -- 36.5

Source for data is 2005 National Immunization Survey. Numerator and denominator data are not available.

Notes - 2005
Source for data is 2004 National Immunization Survey. Numerator and denominator data are not available.

a. Last Year's Accomplishments
N/A --- New Measure for FY07

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor breastfeeding rates of mothers.				X

2. Improve community access to education and support resources to promote breastfeeding by providing multiple venues.			X	
3. Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps (TTS).			X	X
4. Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.			X	
5. Assist Texas worksites to become designated through the Mother Friendly Worksite Program and provide follow-up support.			X	X
6. Assist WIC in the development and implementation of an in-depth breastfeeding survey.				X
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Breastfeeding among WIC clients averages 70.6%. Data from the 2004 Pregnancy Risk Assessment Monitoring System (PRAMS) indicates that 73.3 % of women reported that they initiated breastfeeding. Of these women, 49% reported that they were still breastfeeding at two -- six months postpartum.

Activity 2: Title V staff have attended both meetings of the Texas Breastfeeding Coalition held to date, Oct. 6, 2006 and March 9, 2007. There was one Peer Counselor Training Workshop in the first quarter of FY2007.

Activity 3: Four applications were received from hospitals and two were approved.

Activity 4: There were 22 Mini I Breastfeeding Workshops with a total of 503 participants and 7 Mini II Breastfeeding Workshops with 189 participants. The one day workshops are designed for health care professionals and others to promote and encourage breastfeeding. In addition, there were two Principles of Lactation Management (POLM) classes with a total of 149 participants and one Lactation Counseling and Problem Solving (LCAPS) class with a total of 37 participants. Participants have included physicians, nurses, nutritionists and others.

Activity 5: All MFWP materials are available through the website. Five applications for MFWP designation were received and four were approved.

Activity 6: The previous survey was reviewed, revised, and is currently being used by WIC.

c. Plan for the Coming Year

Activity 1: Improve community access to education and support resources to promote breastfeeding by providing multiple venues.

Output Measure: Number of new WIC breastfeeding peer counselors trained; number of WIC and non- WIC participants attending training; number of hits to website; number/type of breastfeeding promotion materials produced; number of Texas Breastfeeding Coalition meetings attended; number/type of breastfeeding promotion activities initiated by DSHS.

Monitoring: Review quarterly progress reports from WIC website; review training participants' attendance forms; review materials; review meeting rosters and notes.

Activity 2: Assist Texas hospitals and birthing centers (birthing facilities) to become accredited through Texas Ten Steps.

Output Measure: Number of application packets received; number of birthing facilities accredited; number/type of technical assistance (TA) contacts made; number of birthing facilities that are Mother-Friendly Worksite Program (MFWP) applicants.

Monitoring: Track progress in providing training and TA as requested and follow up with the accreditation process.

Activity 3: Provide breastfeeding training and resources to health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

Output Measure: Number of training sessions provided; number of health care professionals participating in training by race and ethnicity; report on the number and type of strategies developed to involve physicians in breastfeeding promotion; number of hits on Resources for Physicians website.

Monitoring: Track progress in providing training and technical assistance as requested; document training schedule and attendance.

Activity 4: Assist Texas worksites to become designated through the MFWP and provide follow-up support.

Output Measure: Maintain policies posted on website; number of MFWP materials distributed; database of designees developed; number/type of TA contacts; number of new worksites.

Monitoring: Track progress in increasing the number of worksites designated and completing the MFWP evaluation.

Activity 5: Assist WIC in the annual development, implementation, and analysis of an in-depth breastfeeding survey.

Output Measure: Report describing WIC mothers' attitudes and barriers to breastfeeding.

Monitoring: Track quarterly progress on development of survey, implementation of data collection and analysis.

Activity 6: Monitor breastfeeding rates of mothers.

Output Measure: Percent of mothers who initiate breastfeeding prior to hospital discharge; percent breastfeeding at six months; written review of data; data review communicated to external stakeholders including March of Dimes, Health Start, WIC, and Title V fee-for-service and population-based providers.

Monitoring: Review quarterly WIC data, and birth record, Pregnancy Risk Assessment Monitoring System (PRAMS), and National Immunization Survey data as available.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	92	92	92	90	90
Annual Indicator	84.3	82.1	89.2	89.8	91.2
Numerator	313116	309701	340427	345394	357595
Denominator	371429	377374	381441	384465	391888
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	92	92	92	92	92

Notes - 2006
Source for the numerator is the Texas Department of State Health Services Newborn Hearing Screening Database. The denominator is a projection of total live births using vital statistics data from 1991 to 2003 (as of 7/16/07).

Notes - 2005
Source for the numerator is the Texas Department of State Health Services Newborn Hearing Screening Database. The denominator is a projection of total live births using vital statistics data from 1991 to 2003 (as of 7/16/07.)

Notes - 2004
Source: DSHS Center for Health Statistics, Vital Statistics - data for denominator was entered in 2007 following the availability of the 2004 data.

a. Last Year's Accomplishments
Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.

Update: Texas birthing facilities covered by the Newborn Hearing Screening (NBHS) are mandated to electronically transmit records of all infants screened to DSHS. Program staff evaluated the data used for assessing performance and reported results monthly. Birthing facilities were required by Texas law to be certified by DSHS and meet specific performance standards. A facility was out of compliance if the NBHS program was below any of the standards for two (2) of the three (3) months in a quarter. Currently, there are 223 birthing facilities reporting data to DSHS. For the 3rd quarter of fiscal year 2006, 99% of newborns were screened for hearing loss before hospital discharge with a 3% statewide average referral or rescreening rate. During the 4th quarter, 98% of newborns were screened for hearing before hospital discharge with a 3% statewide average referral rate. Facilities that did not meet the minimum requirement of 90% passing rate are out of compliance and were notified monthly through email by the contractor and through certified mail by the department if the issues continued three months following notification. DSHS worked with facility staff to identify solutions to compliance issues.

Performance Assessment: With the passage of mandatory testing in 2000, between 2001 and 2002, the percentage of newborns screened for hearing before leaving the hospital more than doubled. Between 2002 and 2005, the percentage of newborns screened for hearing before

leaving the hospital remained above 80% but below 90%, the annual performance objective. Provisional data for 2006 indicate that the percentage of newborns screened for hearing before leaving the hospital has surpassed the annual performance objective and program staff have chosen to raise the target to 92% for future years. Program activities continue to focus on ongoing technical assistance and continued implementation of a web-based system. These activities should help to maintain progress and achieve the new goal.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and from the tracking system established to manage the program.				X
2. Conduct Texas Early Hearing Detection Intervention (EHDI) Coalition meetings every other month.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Texas birthing facilities covered by the newborn hearing screening (NBHS) mandate electronically transmit records of all babies screened to DSHS. Currently, there are 247 birthing facilities reporting data to DSHS. For the 1st quarter of fiscal year 2007, 98% of newborns were screened for hearing loss before hospital discharge with a 3% statewide average referral or rescreening rate. During the 2nd quarter of fiscal year 2007, 98% of newborns were screened before hospital discharge with a 3% statewide average referral rate. Facilities not meeting the minimum requirement of 90% passing rate are out of compliance and are notified monthly through email by the contractor and through certified mail by the DSHS if the issues continue during month three after the notification. DSHS works with facility staff to identify solutions to the compliance issues.

Activity 2: The TEHDI Coalition completed efforts to identify and resolve problems regarding referrals of children with hearing loss. With HRSA funds, Early Childhood Intervention (ECI) has access to DSHS web-based TEHDI system used in all birth facilities. ECI and Audiology providers now receive electronic referrals, improving follow up efforts. The Coalition disbanded after addressing the referral problems, but DSHS participates with ECI and TEA on issues related to children with hearing loss and deafness.

c. Plan for the Coming Year
Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.

Output Measure: Number of programs monitored by region, percent of compliant versus noncompliant programs.

Monitoring: Document the results of monitoring through monthly reports generated the electronic

monitoring system developed for this project.

Performance Measure 13: *Percent of children without health insurance.*

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	22	20	20	20	20
Annual Indicator	22.4	20.0	20.4	18.9	20.0
Numerator	1341023	1264446	1279078	1224279	1272530
Denominator	5986708	6330256	6263325	6476859	6362648
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	19.9	19.6	19.3	18.9	18.3

Notes - 2006
Provisional data based on population projection from DSHS Epigram and estimated numerator.

Notes - 2005
Source: U.S. Census Bureau,
Current Population Survey, Annual Social and Economic Supplement, 2006

CPS Table Creator for all persons 0 to 17 for variable Health Insurance Coverage. Both numerator and denominator are drawn from this source.

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Notes - 2004
Source: U.S. Census Bureau,
Current Population Survey, Annual Social and Economic Supplement, 2005

CPS Table Creator for all persons 0 to 17 for variable Health Insurance Coverage. Both numerator and denominator are drawn from this source.

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

a. Last Year's Accomplishments
Activity 1: Monitor and report the percentage of children without health insurance.

Update: Title V staff proactively monitor CHIP and Medicaid enrollment figures on a monthly basis and continue to monitor the number of eligible clients who receive services through Title V-funded contractors.

Activity 2: Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.

Update: All Title V contractors actively screen all clients at Title V funded clinics for potential CHIP and Medicaid eligibility. If the client is found to be eligible for CHIP or Medicaid, the contractor's staff assist with the completion of the application form.

Assessment:

For the first time in the past five years (2002 through 2006), Texas has exceeded its annual performance objective with 18.9% of children under 18 without health insurance. With the implementation of the new CHIP perinatal benefit in 2007, there is a potential for more children to have coverage through CHIP, freeing Title V funds to assist more children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor and report the percentage of children without health insurance.				X
2. Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Estimates of children without insurance are developed through the fiscal year.

Activity 2: Through the February 2007, an estimated 15,427 children were referred to Medicaid and/or CHIP by Title V contractors and agency staff.

c. Plan for the Coming Year
Activity 1: Monitor and report the percentage of children without health insurance.

Output Measure: Percent of children without health insurance.

Monitoring: Follow progress in developing periodic child health insurance status report.

Activity 2: Screen all children at Title V-funded clinics for potential CHIP (including the new CHIP perintal benefit) and Medicaid eligibility and make referrals to appropriate programs.

Output Measure: Percentage of children without health insurance who are enrolled into CHIP and other state-funded insurance programs as identified by Title V contractors.

Monitoring: Follow up on each referral.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					23
Annual Indicator				23.7	23.9
Numerator				162380	160793
Denominator				683968	671445
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	22	22	21	20	20

Notes - 2006
Source: WIC Database, Office of Title V and Family Health

Notes - 2005
Source: WIC Database, Office of Title V and Family Health Planning

a. Last Year's Accomplishments
N/A - New Perfomance Measure for FY07

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand development and use of FiT KiDS materials and curriculum in the participating WIC clinic sites.			X	
2. Promote and support breastfeeding as the preferred infant feeding choice for WIC participants.			X	
3. Identify the pregnancy correlates of obesity in early childhood (ages 2 to 4 years) among the WIC population.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: From September 2006 to February 2007, 500 "FiT KiDS" flip charts were ordered from the DSHS WIC Program. The flip chart was created by Southwest Region Educating Communities on Healthy Options and includes information on positive eating, activity, and television behaviors for parents on one side and tips for educators on the other. DSHS provides the package of materials including compact disks, posters, and workbook materials for educators upon request

Activity 2: 70.8% of Born-to-WIC infants were ever breastfed; 51.1% Born-to-WIC infants were

breastfed at certification, 350 WIC breastfeeding peer counselors provided services and 24 persons (made up of WIC directors, breastfeeding coordinators, lactation consultants, hospital nurses and others who are interested in establishing Peer Counselor Programs and training peer counselors) attended the Peer Counselor Trainer Workshop.

Activity 3: Initial analyses have been completed. More rigorous and advanced statistical analyses are still needed.

c. Plan for the Coming Year
Activity 1: Promote and support breastfeeding as the preferred infant feeding choice for WIC participants.

Output Measure: Proportion of WIC participants assigned a risk code indicating complications or potential complications with breastfeeding; percent of Born-to-WIC (infants whose mothers were participants in the program during pregnancy) infants ever breastfed and breastfed at certification; number of WIC breastfeeding peer counselors; number of WIC participants attending the train-the-trainer peer counseling training; number and type of WIC breastfeeding materials produced.

Monitoring: Review quarterly WIC data, review annual WIC survey of breastfeeding per counselors, review training participants' attendance form, review materials.

Activity 2: Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.

Output Measure: Number of WIC participants receiving nutrition education at time of benefit issuance. Type and number of activities included.

Monitoring: Review quarterly WIC performance measure data on nutrition education contacts.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					7.3
Annual Indicator				7.4	7.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7.2	7.1	7	6.9	6.8

Notes - 2006

Source: The source for this provisional data is PRAMS. Final and future reports will come from the Texas birth certificate which will include questions about smoking by trimester.

Notes - 2005
The source for this provisional data is PRAMS. Final and future reports will come from the Texas birth certificate which will include questions about smoking by trimester.

a. Last Year's Accomplishments
N/A - New Perfomance Measure for FY07

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote smoking cessation to women ages 13-44, including pregnant women enrolled in WIC, through a Quitline/Great Start Faxed Referral Model.	X			
2. Review Pregnancy Risk Assessment Monitoring System (PRAMS) data for adults and teens by race and ethnicity to determine rates of smoking in the last three months of pregnancy and to identify co-factors.				X
3. Using Geographic Information Systems (GIS) and related data sets, identify and compare areas of the state with the highest incidence of very low birth weight births and fetal exposure to tobacco, then develop and distribute a list of best practices.				X
4. Develop or procure and provide Texas Healthy Start Projects peer counselors/promotoras with information regarding smoking cessation during pregnancy.			X	
5. Refine messages about timing of cessation in pregnancy.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: 256 contacts were made to the Quitline via the WIC Proactive Tobacco Fax Referral Program. Of these contacts, 67 were pregnant.

Activity 2: Data from the 2004 Pregnancy Risk Assessment Monitoring System (PRAMS) indicates that 16.0% of women surveyed reported that they smoked in the three months before becoming pregnant, 6.9% smoked in the last three months of pregnancy and 13.4% smoked at the time they completed the PRAMS Questionnaire.

Activity 3: Action on this activity has yet to initiate. With the addition of key staff, the action will be initiated and completed in the second half of FY2007.

Activity 4: The six Texas Healthy Start projects focused on developing and promoting a bill for the Texas legislature related to the development of a Fetal-Infant Mortality Review process and adding information regarding the impact of smoking on birth outcomes to the signage required in venues where tobacco products are sold. The projects' staff met on a regular basis to discuss this process and Title V staff participated in these discussions as a resource. The Clinical Toolkit for Treating Tobacco Dependence is available for clinicians to download from the DSHS Tobacco Prevention and Control Program website.

Activity 5: Texas has experienced significant delays in the availability of birth data for 2005, the first year in which the 2003 Certificate of Live Birth will be available in Texas. Once available, analyses will be performed and shared with interested stakeholders.

c. Plan for the Coming Year
Activity 1: Promote smoking cessation to women ages 13-44, including pregnant women enrolled in WIC, through a Quitline/Great Start Faxed Referral Model.

Output Measure: Number of providers participating in the program; number and type of smoking cessation materials developed and/or disseminated; number of Smoking Cessation awareness events targeting women; number of calls made to the Quitline/Great Start by gender, age, pregnancy status, race and ethnicity and county; number of nicotine patches distributed by gender, age, race and ethnicity.

Monitoring: Review Quitline/Great Start data quarterly, review of University of Texas at Austin (UT) data quarterly or annually as appropriate.

Activity 2: Develop or procure and provide Texas Healthy Start Projects peer counselors/promotoras with information regarding smoking cessation during pregnancy.

Output Measure: Number and type of materials provided to Healthy Start Projects; number of technical assistance contacts provided to peer counselors/promotoras.

Monitoring: Track the distribution of information on smoking cessation and document the number of clients connected with peer counselors/promotora.

Activity 3: Review PRAMS data for adults and teens by race and ethnicity to determine rates of smoking in the last three months of pregnancy and to identify co-factors.

Output Measure: Written review of data, including trends; data review communicated to external stakeholders including March of Dimes, Health Start, WIC and Title V fee-for-service and population-based providers; information placed on website, including referral resources for providers and clients.

Monitoring: Annual review of data.

Activity 4: Using Geographic Information Systems (GIS) and related data sets (ie: PRAMS, birth certificate data, etc.), identify and compare areas of the state with the highest incidence of very low birth weight births and fetal exposure to tobacco, and develop and distribute to the public, contractors, regional staff and other stakeholders a list of best practices to address smoking cessation.

Output Measure: Number of areas with very low birth weights and high incidence of fetal exposure to tobacco identified; list of best practices developed and distributed.

Monitoring: Identify data needed and follow up with the identification of best practices.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**

Annual Performance Objective	10.5	10	10	9	7.8
Annual Indicator	9.0	9.5	7.9	7.9	7.6
Numerator	149	162	136	138	136
Denominator	1653654	1701620	1726142	1752098	1786854
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7.6	7.4	7.2	7	7

Notes - 2006
Note that 2004 birth and death related data were updated as of 9/17/07 and provisional data for 2005 and 2006 were adjusted based on a projected linear trend of data from 1996 through 2004.

Population data for Texas are provided by the Center for Health Statistics, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

Notes - 2005
Note that 2004 birth and death related data were updated as of 9/17/07 and provisional data for 2005 and 2006 were adjusted based on a projected linear trend of data from 1996 through 2004.

Population data for Texas are provided by the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

Notes - 2004
Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 9/17/07 following the availability of actual data for 2004.

a. Last Year's Accomplishments
Activity 1: Provide support to the Texas Suicide Prevention Community Network in the implementation of the state suicide prevention plan. The state plan includes identifying resources for targeted communities with the highest incidence of suicide in the state.

Update: Nine communities were enrolled in the Network. Activities included public awareness, education, grant applications, and working with officials to obtain timely surveillance data. Two communities were awarded Community Mental Health Project grants for suicide prevention: the Yellow Ribbon program (a community-based program using a universal public health approach) and the Columbia University TeenScreen program (a national mental health and suicide risk screening program for youth).

Activity 2: Through the Texas Adolescent Mental Health in Primary Care Initiative (TAMHPCI) Workgroup, develop a work plan to conduct mental health screening in primary care through a pilot project.

Update: Through August 2006, the TAMHPCI has conducted the initial adolescent behavioral health training for 160 physicians, nurse practitioners and physician assistants at five feasibility study sites. Three out of the five study sites have implemented the protocol.

Activity 3: The Texas Youth Suicide Prevention Project provides youth suicide screening

prevention and early intervention services by incorporating training of health, school, and community representatives to identify and refer at-risk youth; supporting collaborative efforts of state suicide prevention organizations to increase public awareness; and piloting a health care initiative to identify, assess, and provide referral and follow-up in Houston, Austin, and San Antonio.

Update: The Texas Juvenile Probation Commission has trained over 700 probation staff across the state. Austin ISD has also trained a number of counselors as "Question, Persuade, & Refer" (QPR) Instructors who provided workshops to all counselors and nurses. Through August 2006, QPR Community & School Gatekeeper Workshops trained 124 people in Harris County, 513 people in Travis County, 64 people in Bexar County, and 314 people in other counties.

Through August 2006, DSHS worked to foster support and collaboration with Harris County Hospital District, as well as Baylor College of Medicine Pediatric Emergency Clinic to build a service component that would perform prevention and intervention services to adolescents (ages 10 to 17) who are at risk for suicide. During trainings held in Travis County in October 2005 and January 2006, 140 individuals were trained. During FY06, a total of 135 individuals in other Texas counties were trained.

Activity 4: Collaborate with the Policy Academy to develop a state action plan designed to improve services for people with co-occurring substance abuse and mental disorders.

Update: As part of the SAMHSA Policy Academy initiative, Texas developed plans for addressing co-occurring disorder at a systems level. The Texas State Action Plan was developed in Nov. 2005 with three priorities: communication with the Governor's Advisory Committee on Children at Risk, use of data and information in support of clinical and business case decision-making and policy, and alignment of policies to strengthen screening and assessment, referral and evidence-based priorities. The plan identified key stakeholders and included a communication plan to advise the Governor on the state action plan. It also addressed early identification and intervention for children with behavior problems and their families to prevent entrance into the
juvenile justice and/or child protective services systems.

Performance Assessment: Between 2003 and 2006, Texas has experienced an annual decline in the rate of suicide among youths ages 15 to 19 years of age. Despite a 13.3% reduction in the annual performance objective between 2005 and 2006, the provisional rate reported for 2006 betters the annual objective. Texas has sought and received grant funding to provide youth suicide screening, prevention, and early intervention services. To address the issue of access to mental health providers, the Title V Program and the Mental Health and Substance Abuse Division have teamed to fund a feasibility study that integrates adolescent mental health screening and treatment into a primary care setting. Increased collaboration with the State Child Fatality Review Team may identify leverage points for intervention and training.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide support to the Texas Suicide Prevention Network in the implementation of the state suicide prevention plan.				X
2. For the Texas Youth Suicide Prevention Project, continue to implement the gatekeeper train-the-trainer program in Harris, Travis, and Bexar counties for identified gatekeeper agencies.				X
3. Implement the primary care screening and intervention component of the Texas Youth Suicide Prevention Project.			X	
4. Collaborate with the Policy Academy to develop a state action				X

plan to improve services for co-occurring substance abuse and mental disorders.				
5. Report on suicide deaths of 15 -19-year-olds and develop policy recommendations aimed at prevention.				X
6. Support the Texas Adolescent Mental Health in Primary Care Initiative (TAMHPCI) in the implementation of a feasibility study of behavioral health screening, assessment, treatment and/or referral of adolescents in the primary care setting.				X
7. Collaborate and provide support to DSHS workgroups created by the Mental Health Transformation Workgroup that relate to suicide prevention for adolescents.				X
8.				
9.				
10.				

b. Current Activities
Activity 1: Nine communities are now enrolled in the network. Outreach activities involve community, cultural and faith-based, teacher, student, and parent, as well as public information activities, professional education to physicians and nurses, and development and distribution of educational materials.

Activity 2: Question, Persuade, & Refer Community & School Gatekeeper Workshops trained 1,508 individuals.

Activity 3: Baylor College of Medicine and Harris County Hospital District withdrew from the grant. At present, DSHS is negotiating a contract with San Antonio Center for Health Care Services to perform prevention services in collaboration with Brooke Army Medical Center.

Activity 4: As a result of collaboration the Education Service Center Project was formed. Currently DSHS Title V funds 1/2 FTE at each of 20 Education Service Centers. The School Health Specialists provide training on various health topics to the school districts.

Activity 5: The Texas Center for Health Statistics and the State Child Fatality Review Team produced reports on adolescent suicide.

Activity 6: TAMHPCI is finalizing the data collection and analysis of four of the five sites. One site has withdrawn. A final report will be completed in August.

Activity7: The Mental Health Transformation Workgroup submitted a grant application to U.S. Department of Justice to address the needs of juveniles leaving the juvenile justice system.

c. Plan for the Coming Year
Activity 1: Provide support to the Texas Suicide Prevention Community Network and Community Mental Health Project grants in the implementation of the state suicide prevention plan.

Output Measure(s): Number of communities enrolled in the network; number and type of suicide prevention activities implemented; number and types of grants applied for; number and types of grants secured to advance state plan goals; number of projects awarded; number of CFRTs receiving training on goals of state suicide prevention plan and process for enrolling in the network.

Monitoring: Track the progress of the Network; track the activities within participating communities; review quarterly CFRT prevention reports submitted by the local CFRTs.

Activity 2: For the Youth Suicide Prevention Project, continue to implement the gateway train-the-

trainer program in Harris, Travis, and Bexar counties for identified gatekeepers (e.g., Texas Youth Commission, Texas Department of Family and Protective Services).

Output Measure(s): Number of trainings completed by county; numbers of agencies and participants.

Monitoring: Quarterly reports on the number of participants trained and trainings completed; status of suicide data in targeted counties.

Activity 3: Implement the primary care screening and intervention component of the Youth Suicide Prevention Project.

Output Measure(s): Suicide screening tool developed and implemented, numbers of clients served.

Monitoring: Updates provided in grant reporting requirements.

Activity 4: Report on suicide deaths of 15 to 17-year-olds and develop policy recommendations aimed at prevention.

Output Measure(s): Public awareness/educational materials developed; suicide deaths of 15 to 17-year-olds reported in the State Child Fatality Review Team Committee annual report; number of trainings on developing suicide prevention initiatives presented to CFRTs; number of local initiatives developed by CFRTs; development of SCFRT subcommittee on prevention to collect local CFRT recommendations and prevention initiatives through quarterly CFRT prevention reports.

Monitoring: Track materials that are developed; provide updates of 15 to 17-year-old suicide deaths and recommendations at quarterly State Committee meetings.

Activity 5: Convene the TAMHPCI partners to plan and implement the initial phase of the large scale comparative study.

Output Measures: Contract developed between DSHS Title V and Texas Tech University, report on the inital phase.

Monitoring: Track the progress of contract development and the progress of the initial phase.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	55	55	55	55	55
Annual Indicator	53.5	52.4	48.8	52.9	53.3
Numerator	2660	2690	2674	2827	2889
Denominator	4976	5133	5482	5342	5417
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-					

year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	55	55	55	55	55

Notes - 2006
Source: Very Low Birth Weight deliveries data is from DSHS, Bureau of Vital Statistics, Natality Files, 1996 - 2003.

Estimated data is based on 1996-2003 data (as of 7/16/07).

Notes - 2005
Source: Very Low Birth Weight deliveries data is from DSHS, Bureau of Vital Statistics, Natality Files, 1996 - 2003.

Estimated data is based on 1996-2003 data (as of 7/16/07).

Notes - 2004
Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

a. Last Year's Accomplishments
Activity 1: Develop a process to facilitate appropriate referrals for at-risk clients to facilities for high-risk deliveries and neonates and ensure the continued assessment of perinatal care facilities as basic, specialty or subspecialty by using Geographic Information Systems (GIS) maps, developing and disseminating educational materials for providers, soliciting input from stakeholders, and tracking referral patterns in selected areas.

Update: Changes in the Family & Community Health Services website delayed the posting of this information. Staff members plan to procure updated data and complete the activity in FY2007.

Performance Assessment: In 2006, the percentage of VLBW deliveries at facilities for high-risk deliveries and neonates was 53.3%, which is below the annual performance objective of 55%. This indicator has experienced nearly no change from 2002 through 2006. Activities will focus on identifying barriers to seeking care at appropriate facilities and information for providers of the existence and location of these facilities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Analyze birth data to identify areas in Texas where very low birth weight infants are not being delivered at Level III facilities.				X
2. Develop a process to facilitate appropriate referrals for at-risk clients to facilities for high-risk deliveries and neonates and assess perinatal care facilities as basic, specialty, or subspecialty by using Geographic Information System tools.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Key staff additions will facilitate the completion of this task in the remainder of FY07.

Activity 2: Key staff additions will facilitate the completion of this task in the remainder of FY07.

c. Plan for the Coming Year
Activity 1: Develop a process to facilitate appropriate referrals for at-risk clients to facilities for high-risk deliveries and neonates and ensure the continued assessment of perinatal care facilities as basic, specialty or subspecialty by using Geographic Information Systems (GIS) maps, receiving input from local providers, developing and disseminating educational materials for providers, soliciting input from stakeholders, and tracking referral patterns in selected areas.

Output Measure: Number of referrals (origins/destinations) made for at-risk clients to facilities for high-risk deliveries; number of GIS maps developed; number and type of materials developed; number of materials distributed; number of stakeholder meetings convened and/or amount and type of input received from local providers; number of stakeholder organizations represented at meetings.

Monitoring: Document minutes from stakeholder meetings or documentation of other means of receiving input from local providers and track referral patterns.

Activity 2: Provide an analysis of barriers to delivery in high risk facilities for high risk mothers using birth record data, data from the Hospital Survey Unit, and GIS technology.

Output Measure: Report detailing sociodemographic and geographic barriers.

Monitoring: Quarterly progress reports.

Activity 3: Develop a letter to practicing obstetricians and other stakeholders that includes high risk perinatal care facilities as well as regional maps of their locations.

Output Measures: Letters to providers; lists of perinatal care facilities; maps of the locations of perinatal care facilities.

Monitoring: Number of letters sent annually.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	85	85	85	85	85
Annual Indicator	79.3	79.7	81.6	82.0	82.2
Numerator	295282	300927	311089	315443	322754
Denominator	372369	377374	381441	384465	392830
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5					

and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	85	85	85	85	85

Notes - 2006
Estimated data is based on 1996-2003 data (as of 7-16-07)

Notes - 2005
Estimated data is based on 1996-2003 data (as of 7-16-07)

Notes - 2004
Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

a. Last Year's Accomplishments
Activity 1: Through the Texas Comprehensive Women's Health Initiative grant, implement a process to develop and implement an action plan to improve the comprehensiveness of the women's health care service delivery system in DSHS Health Service Regions (HSRs) 9/10 and 11, predominantly Hispanic areas with low utilization of early entry into prenatal care.

Update: Through August 2006, Su Clinica Familiar (SCF) convened a workgroup that met on a monthly basis to assess the health care service status in Cameron County and strengthen referral networks. End products were a brochure on breast health and mammograms that included a referral list and a plan to develop a referral booklet for the county to facilitate providers in making referrals.

Activity 2: Allocate funds through a population-based competitive Request for Proposals (RFP) in targeted areas/subpopulations of the state to obtain the best birth outcomes.

Update: A competitive RFP released in October 2005 targeted four areas: adolescent pregnancy, low birth weight, STD prevalence, and adequacy of prenatal care. Eight awards were made as part of this RFP process. With contractors allowed to focus on multiple topic areas, four contractors addressed adequacy of prenatal care; three addressed adolescent pregnancy; three addressed sexually transmitted diseases; and one addressed low birth weight. This first year of funding was a truncated year: contracts started on January 1, 2006, and ended on August 31, 2006.

A continuation RFP was released in the spring of 2006 that resulted in an additional nine contractors. With contractors allowed to focus on multiple topic areas, six contractors addressed adequacy of prenatal care; two addressed adolescent pregnancy; one addressed sexually transmitted diseases; and two addressed low birth weight. These contracts started September 1, 2006, and will end on August 31, 2007 with the possibility of renewal based on performance, evaluation, and the availability of funds.

Performance Assessment: The percentage of women receiving first trimester prenatal care was consistent for 2005 and 2006 after a gradual decline beginning in 2000. Texas has yet to meet or pass the annual performance objective of 85% for this measure. The Texas Title V Program continues to fund 10 projects that address early entry into prenatal care in high-need areas and among population groups with low utilization of prenatal care. Given the large population of undocumented immigrants in Texas, activities to encourage regionally located staff to provide education, outreach, and referral to the CHIP Perinatal program will address this challenge.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Allocate Title V funds through a population-based competitive or continuation Request For Proposals (RFP) in targeted areas/subpopulations of the state to obtain the best birth outcomes.			X	X
2. Review curricula for promotora/community health worker-based home visiting programs to identify and/or develop a curriculum for implementation in identified geographic locations in Texas, and promote to external stakeholders.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: In FY2006, competitive and continuation RFP were released in targeted areas/subpopulations of the state to address teen pregnancy, STDS, adequacy of prenatal care and low birth weight. A total of 17 awards were made, eight continuation and nine new awards.

Activity 2: To date, several models/curricula have been reviewed, including the Nurse-Family Partnership, Partners for a Healthy Baby (Florida State University), Healthy Families Travis County and the Mother-Love Model. Also, there are several home visiting models being tested through the Title V Population-based grant program. Staff have reviewed these models and are monitoring their implementation and effectiveness.

Title V staff have worked with the DSHS Community Health Worker (CHW) Program to assist the program in developing its strategic plan for the future and to identify ways in which Title V can work with the CHW Program. To date, more than 600 promotoras/community health workers have been certified through the DSHS CHW Program, and there are 11 certified training sites. In the spring of FY07, the CHW Program was moved into the Office of Title V and Family Health. The move will provide greater opportunities to explore ways for CHWs and promotoras to promote the importance of prenatal care during the first trimester.

c. Plan for the Coming Year

Activity 1: Allocate Title V funds through a population-based competitive or continuation RFPs in targeted areas/subpopulations of the state to obtain the best birth outcomes.

Output Measure: List of models and/or best practices for improving birth outcomes; list of target areas, list of awards made, quarterly reports of contract performance.

Monitoring: Review contractor activities and progress.

Activity 2: Health Service Regions develop a population-based activity to ensure referral to the CHIP Perinatal Program and Medicaid.

Output Measure: Number of Service Level Agreements that identify activity and number of pregnant women referred for each program.

Monitoring: Review quarterly reports.

D. State Performance Measures

State Performance Measure 1: *Change in percentage of CSHCN living in congregate care settings as percent of base year 2003*

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					95
Annual Indicator				99.3	100.1
Numerator				1606	1619
Denominator				1617	1617
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	90	85	82	80	80

Notes - 2006
Source: Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2006.

The FY06 number exceeds the base year 2003. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments.

Notes - 2005
Correction to data obtained from Health and Human Services Commission Report.
The number reported for 2005 should be changed from 1587 to 1606.

a. Last Year's Accomplishments
Activity 1: Provide, or support the provision of, permanency planning (including alternative families where appropriate and available) and case management services to families of CSHCN, especially those suspected to be at risk of, or in, out-of-home placement.

Update: During FY06, regional staff and CSHCN Services Program (SP) contractors assisted 1,926 CSHCN and their families with permanency planning. In response to Senate Bill 368, the Texas Health and Human Services Commission's (HHSC) report dated December 2006 noted that 1,619 children resided in institutions for the period ending 8/31/06. Of the total, 1,455 children had been recommended for transition to the community, but had not yet transitioned. During the twelve month reporting period ending 8/31/06, 97 children moved to less restrictive environments (other than family-based settings). An additional 183 children moved to family-based settings. The Department of Aging and Disabilities Services (DADS) received funding from the 79th Texas Legislature (2005) to serve additional persons, including children, from the Medicaid waiver interest lists. As of 8/31/06, 175 of 2,193 children released from the Medically Dependent Children's Program (MDCP) interest list were enrolled in MDCP. HHSC continued to contract with EveryChild, Inc., to develop and implement a system of family-based alternatives in several areas in Texas.

Activity 2: Fund respite and other family support services through contracts and CSHCN (CSHCN SP) health care benefits - family support services (FSS).

Update: During FY06, ten (10) contractors provided respite or other family support services for

nearly 1,200 CSHCN and their families. Twenty (20) CSHCN and their families received respite through CSHCN SP, 8 CSHCN received van modifications, 10 received home modifications, and 2 received other family support services. Expenditures for FSS through the CSHCN SP totalled $118,317. All CSHCN SP regional staff received training on FSS.

Activity 3: Participate in state-level committees/task forces to collaborate with consumers, providers, and other state and private agencies to support permanency planning and family-based community living options for CSHCN who are at risk of placement or who currently reside in institutions or congregate care settings.

Update: Title V staff continued to participate in such forums as the Children's Policy Council (CPC), Promoting Independence Advisory Committee (PI), Money Follows the Person (MFP) statewide and regional workgroups, and Texas Integrated Funding Initiative (TIFI). CSHCN SP contractors, and regional DSHS staff participate in community forums, such as conferences, committee meetings, and local Community Resource Coordination Groups (CRCGs).

Performance Assessment: As of 2/28/06, 1,596 children resided in institutions. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments. Overall, the number of children living in ICF/MRs and state schools has declined by 27% in the past 3.5 years while the number of children residing in less restrictive residential settings has risen 62%.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide, or support the provision of, permanency planning and case management services to families of CSHCN at risk of, or in, out-of-home placement.		X		
2. Fund respite and other family support services through contracts and CSHCN SP healthcare benefits.		X		
3. Participate in state-level committees/task forces to collaborate with stakeholders to support permanency planning and family-based community living options for CSHCN who are at risk for or who are placed in institutions/congregate care settings.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: During the first half of FY07, DSHS staff and CSHCN SP contractors assisted 891 CSHCN and their families with permanency planning. A standardized permanency planning letter was developed for CSHCN and their families. The HHSC report for Senate Bill 368 noted that 1,619 children resided in institutions for the period ending 8/31/06. Texas received Money Follows the Person (MFP) federal funding to help persons residing in a facility return to the community. As of 1/31/07, 471 of 4,236 children released from the Medically Dependent Children's Program (MDCP) interest list enrolled in MDCP. The number of children released from other Medicaid waiver programs interest lists was not available.

Activity 2: During the first half of FY07, 10 contractors served nearly 1,200 CSHCN and their

families.   CSHCN SP provided FSS to eligible clients including respite, van and home modifications, and other family support services. CSHCN SP expended $24,270 for FSS during this period.

Activity 3: Title V staff continues to participate in such forums as the Children's Policy Council (CPC), Promoting Independence Advisory Committee (PI), Money Follows the Person (MFP) statewide and regional workgroups, Texas Integrated Funding Initiative (TIFI), and Texas Council in Developmental Disabilities (TCDD). CSHCN SP contractors and Regional staff participate in community forums, such as conferences, committee meetings, and local Community Resource Coordination Groups (CRCG).

c. Plan for the Coming Year

Activity 1: Provide, or support the provision of, permanency planning and case management services to families of CSHCN at risk of, or in, out-of-home placement.

Output Measures: Number of CSHCN assisted with permanency planning by CSHCN SP regional and contractor case management staff; contractor quarterly reports and quarterly regional activity reports; information on placements of CSHCN with alternative families, and admissions and discharges for CSHCN from congregate care settings (nursing homes, state schools, ICFs-MR), as data is available.

Monitoring: Quarterly regional activity reports, contractor quarterly reports, and data from HHSC.

Activity 2: Fund respite and other family support services through contracts and CSHCN SP health care benefits.

Output Measure: Number and type of respite and other family support services programs funded through CSHCN SP contracts. Number of CSHCN provided respite and other family support services through CSHCN SP contractors and health care benefits.

Monitoring: Quarterly reports from the CSHCN SP health care benefits database and contractors.

Activity 3: Collaborate with contractors, state agencies, and other entities to support permanency planning and family-based living options for CSHCN who reside in or are at risk of placement in congregate care settings.

Output Measures: Documentation of participation in and recommendations/actions of related committee/agency meetings; reports of related contractor activities; and participation in interagency reviews as directed.

Monitoring: Stakeholder meeting reports on relevant meetings attended by CSHCN SP staff, contractor quarterly reports, and reports of other activities.

State Performance Measure 2: *The percent of obesity among women ages 18 to 44*

Tracking Performance Measures

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					23
Annual Indicator				23.6	24.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

	2007	2008	2009	2010	2011
Annual Performance Objective	22.5	22	21.5	21	20.5

Notes - 2006
BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

Notes - 2005
BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

a. Last Year's Accomplishments
Activity 1: Work with the WIC program to assess the effectiveness of the "Fit Families" Program on increasing knowledge and impacting behavior among women of childbearing age in the WIC participating clinic sites.

Update: Through August 2006, all WIC local agencies have received their FiT KiDS materials. Texas WIC staff decided to partner with the USDA Southwest Region (Texas, Oklahoma, New Mexico, Louisiana, Arkansas) to do an evaluation of "Fit Families" materials. The primary goal of the evaluation was to determine what participants have learned from the FiT KiDS materials, if they have made any changes in their lifestyle based on the information, and how much they valued the information. A second goal was to determine from staff specific aspects of the implementation that have been successful. Evaluation data will not be available until the end of FY07.

Activity 2: Assess the effectiveness of the "WIC Wellness Works" (WWW) program on improving fruit and vegetable consumption, physical activity, and role behavior and work climate in the targeted WIC clinic sites among WIC employees.

Update: Through August 2006, over 1000 WIC staff across Texas participed in WWW. WWW is in 21 local agencies and 186 individual clinics. Assessment of participation was scheduled for FY07.

Activity 3: DSHS regional staff, under the direction of the Nutrition, Physical Activity and Obesity program staff, conduct skills building workshops and provide technical assistance in order to facilitate the development of community collaborations around the topics of nutrition and physical activity.

Update: In May of 2006, regional nutritionist staff in HSR 9 facilitated a skill building workshop at Midland Memorial Hospital, in the city of Midland for Midland County Area Community Leaders. Twenty-five members attended the workshop and included representatives from Midland Chamber of Commerce, medical clinics & hospitals, physical therapy, Midland ISD, grocer, child care agency, television and printed media, social services, parks & recreation department, American Cancer Society, American Heart Association, a Community Health Center, the Girls Scouts, Head Start, Texas Cooperative Extension, Region 18 ESC, faith-based organization, and Midland College. As a result of the workshop, a Tall City Health Coalition was formed and has scheduled monthly meetings, created a banner for a community media blitz to increase awareness around the topics of nutrition and physical activity in relation to obesity prevention and to market the coalition's existence.

In HSR 6, FY06 skill building workshop resulted in a response from the area Texas Cooperative Extension Office, which coordinates the Wharton County Fit Kids Collaborative to conduct the FiT KiDS program in area schools and hold a special field day event in which the DSHS HSR Regional Nutritionist staff provided technical assistance.

Performance Assessment: In the two years for which data are available, there has been a slight

increase in the percent of women between the ages of 18 to 44 years who report being obese. Activities will focus on promoting the WIC Wellness Works, a program that uses WIC staff to model the benefits of good nutrition and physical activity, and projects and educational events with the regionally located staff.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Review the effectiveness of the "WIC Wellness Works" program on improving fruit and vegetable consumption, physical activity, role behavior and work climate in targeted WIC clinic sites among WIC employees				X
2. DSHS regional staff conduct skill building workshops and provide technical assistance in order to facilitate the development of community collaborations around the topics of nutrition and physical activity.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Currently 1,500 WIC staff across Texas are participating in WIC Wellness Works (WWW). WWW is in approximately 42 local agencies. Qualitative data for FY05 and FY06 has been made available to DSHS for review. Initial impressions of the data are positive.

Activity 2: In FY07, skill building workshops designed to facilitate the development of community collaborations around the topics of nutrition and physical activity with an emphasis on policy and environmental change, were held throughout Health Service Regions 6, 7, 8, and 9. Initial evaluations for all workshops showed a positive response from attendees regarding the information and data presented as well as speaker's knowledge and expertise. No six-month evaluation follow-up information has been provided to date.

c. Plan for the Coming Year

Activity 1: Review the effectiveness of the "WIC Wellness Works" program on improving fruit and vegetable consumption, physical activity, role behavior and work climate in targeted WIC clinic sites among WIC employees.

Output Measure: Number of WIC clinic sites participating in "WIC Wellness Works"; number of WIC staff participating in "WIC Wellness Works"; number of WIC clinic sites showing improved fruit and vegetable consumption, physical activity, and role behavior at end of one year's enrollment in "WIC Wellness Works."

Monitoring: Review of quantitative and qualitative analyses of changes in fruit and vegetable consumption, physical activity, and role behavior.

Activity 2: DSHS regional staff, under the direction of the Nutrition, Physical Activity and Obesity program staff, conduct skill building workshops and provide technical assistance in order to facilitate the development of community collaborations around the topics of nutrition and physical

activity.

Output Measure: Number of participants in each workshop; number and type of organizations participating in the community collaborations; number and type of topics addressed; workshop evaluation completed; six-month follow-up on activities undertaken since completion of workshop, summary reports on activities of existing community collaborations.

Monitoring: Track progress on workshops' evaluations and six-month follow-ups.

State Performance Measure 3: *Percent of licensed child care centers in metropolitan counties that have no deficiencies in operational policies that address health and safety of children.*

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					90
Annual Indicator				0.0	
Numerator				0	
Denominator				55	7500
Is the Data Provisional or Final?				Final	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	90	90.5	91	91.5	92

Notes - 2006
The measure has been refined based on review of activities in FY07. Numerator is not available at this time.

Denominator is an estimate of total licensed child care centers in metropolitan areas.

Notes - 2005
Source:
http://www.tea.state.tx.us/student.assessment/reporting/results/swresults/taks/2006/g3e.pdf

Texas Education Agency, Student Assessment Division

a. Last Year's Accomplishments
Activity 1: Continue the effort of training childcare health and medical consultants to provide consultation in support of health promotion and risk reduction strategies to childcare centers throughout Texas.

Update: Through August 2006, one training session for Child Care Health Consultants (CCHCs) was held. Eight (8) persons successfully completed the CCHC training and are now eligible to serve as Child Care Health Consultants within Texas.

Activity 2: Collaborate with the Texas Workforce Commission (TWC) to facilitate communication and coordination between the 28 local workforce development boards and the Healthy Child Care Texas (HCCT) Initiative and to encourage their participation in HCCT by allowing workforce child development specialists to become either National Training Institute (NTI) trainers or CCHCs, thus increasing the network of CCHCs. The plan is to train workforce staff in 5-6 local workforce areas per year.

Update: A proposal was developed for state level staff at TWC offering to train one person in each of the 28 Local Workforce Development Board areas to be an NTI Trainer or a child care health consultant (CCHC). State level staff at TWC supported the concept and the proposal was

presented to local board level staff in December 2005. While some boards expressed interest, the childcare subsidized rules were revised significantly in January 2006, narrowing the use of quality improvement funds to primarily supporting school readiness initiatives and creating a barrier to the development of an infrastructure for CCHC and NTI trainers through TWC collaboration.

Since February 2006 the HCCT initiative has spent a significant amount of time strategically planning how HCCT would support the Texas Early Childhood Comprehensive Systems initiative, Raising Texas. During this time, two non-profit agencies in different locations, one in Austin and one in Corpus Christi, received funding from different outside sources to develop small healthy child care infrastructures within their own communities.

Activity 3: Childcare health and medical consultants consult with, train and educate the early care and education community and parents on topics related to child health and safety. The consultations and training will support the five components of the State Early Childhood Comprehensive Systems Grant, which include parent education, family/community support, medical home, early care and education, and social emotional development.

Update: Under the Healthy Child Care America Grant, Campfire USA coordinated reporting by CCHCs. CCHCs reported activities to Campfire USA by sending in activity-reporting cards. These cards were forwarded to HHSC for entry into the Service Counter Database. This system was eventually eliminated once the program was no longer grant-funded. The development of a new integrated online database began in October 2005 and was completed and uploaded to the website in February 2006.

Activity 4: CCHCs address problem areas in childcare facilities as identified in the DFPS childcare licensing infraction reporting.

Update: Through August 2006, most CCHCs were self-employed and provided consultation when hired by childcare facilities. Some worked in grant-funded positions to address specific areas of need. A system was not developed to coordinate CCHC activities with childcare licensing infractions during this reporting period.

Assessment: Future efforts to maximize the influence of the CCHC model and other methods to improve health behaviors in the early and child care settings will focus on identification and coordination with existing stakeholders.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assess childcare infrastructure in the state at the regional and local level and identify priority areas of need for Child Care Health Consultation services.				X
2. Convene a summit of early childhood health and early care and education stakeholders to develop a best model for implementation of a Child Care Health Consultant (CCHC) program, define priorities in CCHC curriculum, and scope of practice.				X
3. Plan and develop a pilot project for Child Care Health Consultation based on identified best practices at a site identified as having high need for Child Care Health Consultant Services.				X
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: An assessment of the childcare infrastructure (the need for and utilization of child care health consultants) was initiated in FY2006 to assess the childcare infrastructure at that regional and local level and to identify Child Care Health Consultation priority needs.

Activity 2: As part of the Texas Early Childhood Comprehensive Systems (TECCS) Implementation Plan, priority areas outlining how Healthy Child Care Texas (HHCT) would support each of the five component areas of the TECCS initiative were established.

HCCT Task Force members and NTI trainers were then able to establish activities for each goal and objective, with responsible parties and timelines attached. The Scope of Practice was broadened for both NTI Trainers and CCHCs to include additional training/certification in such areas as Infant Mental Health, Positive Behavioral Support and a requirement that all NTI Trainers and CCHCs be registered in the Texas Early Care and Education Career Development System's Trainer Registry.

Activity 3: A workgroup made up of staff from the Office of Title V and Family Health and HHSC was created to identify best practices and establish a strategy for an efficient and effective pilot program. The purpose will be to develop infrastructure that promotes best practices in health promotion and risk reduction in early care and education childcare settings through the use of Healthy Child Care Texas, NTI trainers and CCHCs, and Community Health Workers (promotoras).

c. Plan for the Coming Year
Activity 1: Assess childcare infrastructure in the state at the regional and local level and identify priority areas of need for Child Care Health Consultation services and other options for providing information to licensed child care centers.

Output Measure: Implementation of assessment survey(s); number of areas of the state assessed.

Monitoring: Follow-up progress on assessment planning and implementation.

Activity 2: Assess the options available and feasibility for developing an online child care health consultant course.

Output Measure: Evaluation of the options and feasibility of developing an online course.

Monitoring: Review of quarterly progress reports.

Activity 3: Assess the feasibility of developing a pilot project for Child Care Health Consultation based on identified best practices at a site identified as having high need for Child Care Health Consultant Services.

Output Measure: Evaluation of the feasibility of developing a pilot project.

Monitoring: Review of quarterly progress reports.

State Performance Measure 4: *The proportion of women between the ages of 18 and 44 who are current cigarette smokers.*

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					17.5
Annual Indicator				18	15.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	17	16.5	16	15.5	15

Notes - 2006
BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

Notes - 2005
BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

a. Last Year's Accomplishments
Activity 1: Promote smoking cessation to women ages 13-44, including pregnant women, through a Quitline/Great Start Faxed Referral Model.

Update: Through August 2006, eight WIC sites were participating in the WIC Proactive Tobacco Fax Referral Program (PTFRP). Through August 2006, 195 contacts were made to the Quitline via the WIC PTFRP. Training was provided for WIC offices in Jefferson, Hardin, and Orange Counties in January and the program was implemented in February 2006. Site visits, phone calls, and emails were used to monitor and evaluate the program with the WIC staff.

Activity 2: Collaborate with WIC program and the Texas University at Austin to promote smoking cessation to women ages 13-44, including pregnant women, through a billboard campaign and Quitline/Great Start promotion.

Update: Six WIC providers participated in the program. Television and radio advertisements were implemented to promote the Quitline in FY2006. Ads ran statewide mid-November through mid-February, followed by a targeted placement in Jefferson County in March 2006 and in Harris County for the first two weeks of the same month. Newspaper ads and inserts were run in Jefferson County from June 19-July 31, 2006. The newspaper ads generated an increase in calls to the Quitline from Jefferson County, probably because they highlighted the availability of free nicotine replacement therapy, which was not included in broadcast advertisements as this service was only available to Jefferson County residents. In May 2006, when no media was running, 11 people from Jefferson County contacted the Quitline (10 female, including one pregnant client). There were 54 callers in June (35 female, 1 pregnant) and 163 callers in July (119 female, 7 pregnant). There was an immediate drop-off in August 2006 when the media quit running -- 38 callers (30 female, 1 pregnant). Billboards were not developed in FY06 due to budget constraints and the determination that outdoor media is not as effective as broadcast media.

Activity 3: Conduct a survey addressing tobacco habits and history among women of childbearing age.

Update: University of Texas developed a survey tool that is administered at various times during the pregnancy: a screening form to determine smoking habits (if any) during pregnancy, a smoker

survey form that asks about smoking habits, a form that is completed immediately after the child is born, and a fourth form that is completed one to two months after the child is born. These forms are designed to measure the client's success at cutting down or quitting, whether materials were received to help the client quit smoking, and whether the client found any materials helpful.

Activity 4: Using Geographic Information Systems (GIS) and related data sets, identify and compare areas of the state with the highest incidence of very low birth weight births and fetal exposure to tobacco, and develop and distribute a list of best practices to address smoking cessation.

Update: Due to organizational changes and staff turnover among the data and research unit, staff was not able to investigate the stability of cigarette smoking during pregnancy at the census-tract level in Texas from 1994 through 2003.

Activity 5: Develop and provide Texas Healthy Start Projects peer counselors/promotoras with information regarding smoking cessation during pregnancy.

Update: In FY 2006, the six Texas Healthy Start projects focused on developing and promoting state legislation for the development of a Fetal-Infant Mortality Review process in Texas and to add information regarding the impact of smoking on birth outcomes to posted signs where tobacco products are sold. The projects met on a regular basis to discuss this process and Title V staff participated in these discussions as a resource.

Performance Assessment: In the two years for which data are available, there has been a slight decrease in the number of women in the preconceptional period (18 to 44 years of age) who self-report cigarette smoking. The current rate is nearly two percentage points below the annual performance objective for 2006. Activities will focus on providing technical assistance to communities and the statewide tobacco control program and continuing to draw attention to the link between SIDS and environmental tobacco smoke.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work to expand the questions asked on the BRFSS to understand attitudes and knowledge of tobacco use among women of childbearing age.				X
2. Provide technical support, guidance and resources to local community groups that identify women of childbearing age as a special population disparately affected by smoking.				X
3. Work with the Tobacco Prevention and Control Program to ensure that annual media campaign includes messages targeting women of childbearing age.				X
4. Develop materials that highlight the link between environmental tobacco smoke and Sudden Infant Death Syndrome (SIDS).				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Additional questions that focus on tobacco use were not added in FY07. It is unlikely that these questions will be added. Funding was directed to add family planning questions and breastfeeding questions to the 2007 BRFSS.

Activity 2: The primary community-based organization that has identified women of childbearing age as a special population disparately affected by smoking in Texas is the March of Dimes (MOD). The MOD has requested data regarding smoking rates for women of childbearing age women on a regular basis via their request for general data and PRAMS updates.

Activity 3: Television, radio, outdoor and online cessation ads ran in Houston and Beaumont Oct. 23-Nov. 27, 2006. Television, radio, newspaper, outdoor and online ads ran in Amarillo and Tyler Dec. 4-25, 2006 and Feb. 12-March 5, 2007.

Activity 4: Title V staff have developed a brochure entitled Information for Parents of Newborn Children that discusses various aspects of parenting in the first few weeks and months postpartum. Currently, information on newborn screening, immunization, postpartum depression and shaken baby syndrome is included. Staff are discussing adding information on Sudden Infant Death Syndrome and safe sleep, including any links to environmental tobacco smoke exposure.

c. Plan for the Coming Year

Activity 1: Provide technical support, guidance and resources to local community groups that identify women of childbearing age as a target population.

Output Measure: Number and location of community groups that have identified women of childbearing age as a target population; number of strategies developed to impact women of childbearing age; and number of data requests and/or technical assistance requests regarding smoking rates for women of childbearing age women filled.

Monitoring: Review community group meeting minutes and HSR Tobacco Specialists' notes.

Activity 2: Work with the Tobacco Prevention and Control Program to ensure that annual media campaign includes messages targeting women of childbearing age.

Output Measure: Number of media campaign meetings attended; number of media strategies developed and implemented targeting women of childbearing age; and evaluation efforts for media strategies targeting women of childbearing age.

Monitoring: Notes from media campaign meetings attended. Media evaluation reports.

Activity 3: Develop materials that highlight the link between environmental tobacco smoke and Sudden Infant Death Syndrome (SIDS).

Output Measure: Number and type of materials developed and distributed. Number of hits to website page containing information on the link between environmental tobacco smoke and SIDS.

Monitoring: Data reports for web hits and materials distributed.

State Performance Measure 5: *The prevalence of at-risk for obesity and obesity among adolescents enrolled in high school*

Tracking Performance Measures

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006

Annual Performance Objective					28
Annual Indicator				29	29
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	27	26	25	24	23

Notes - 2006
Source: Texas, 2005 Youth Risk Behavior Survey (YRBS) Results.
http://www.cdc.gov/HealthyYouth/yrbs/pdf/mortality/texas.pdf

Notes - 2005
Estimate is based on 2005 YRBS. Since YRBS is a sample survey, numerator and denominator data are not applicable.

Source: Texas, 2005 Youth Risk Behavior Survey (YRBS) Results.
http://www.cdc.gov/HealthyYouth/yrbs/pdf/mortality/texas.pdf

a. Last Year's Accomplishments
Activity 1: Work with WIC to describe the food consumption patterns found from the Toddler Epidemiological Study conducted by the University of Texas at Austin.

Update: The "Feeding Your Toddler and Young Child" study aimed to explore the dietary intake of children ages 1 to 5 in Texas, specifically to compare the Texas WIC population to the general population. The study also explored parental beliefs, feeding practices, and other attitudes and behaviors related to child feeding. The study questionnaire was revised based on data from the pilot and stakeholder input. The survey was administered the following year and was not identified as a reported Title V activity for the 2007 MCH Block Grant Application.

(The subsequent survey began in September 2006 and data analysis began in January 2007. Preliminary analysis included descriptive statistics, reliability analysis for each scale, and comparisons between the three economic categories across items and scales. Regression analysis has been used to identify factors associated with fruit, vegetable, sweets, sweetened drinks, and WIC foods intake. WIC staff continue to analyze and plan to disseminate results in the future.)

Activity 2: Work with the WIC program to assess the effectiveness of the "Fit Families" Program on increasing knowledge and impacting behavior among women and children in the WIC participating clinic sites.

FiT KiDS materials were developed and used by WIC staff to train approximately 50 WIC staffers at the National WIC Association Annual Conference held in Houston in April 2006. Staff received materials, trained other staff, and integrated the materials into clinic nutrition education activities. Evaluation was planned for FY07 so that clinics would have sufficient time to train staff and integrate the materials into existing nutrition education efforts. A final report was to be available in fall of 2007.

Activity 3: Collaborate with the School Physical Activity Nutrition (SPAN) group to collect data on demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th, 8th and 11th grade children.

Update: No SPAN data were collected since FY05.Family Health Research and Program Development staff has worked on the analysis of the previously collected SPAN data. Literature reviews have been completed to strengthen the SPAN data collection instrument prior to reinstating data collection. Summary analyses comparing SPAN II 2000-2002 data to SPAN III

2004-2005 data show the prevalence of overweight increased among both eighth- and eleventh-graders, but slightly dropped among fourth-graders in Texas from 25.6% to 23%. Additionally, in May of 2006, the final analyses of 2004-2005 SPAN III data for nine counties that contracted with DSHS for local data collection was completed. Updates were made to DSHS agency fact sheets on overweight and obesity for the state. Texas SPAN III data was presented to the Texas Health Policy Institute's Partnership for a Healthy Texas Conquering Obesity group to support and guide prioritization of advocacy efforts for the 80th Texas Legislative Session in the fall of 2006. In addition, three meetings took place between DSHS and SPAN I.

Performance Assessment: Nearly 30% of adolescents self report themselves to be obese. Activities will focus on innovative projects and surveillance systems that will provide data upon which evidence based programs can be developed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote and support breastfeeding as the preferred infant feeding choice for Texans among community leaders and women throughout the population.			X	X
2. Implement and evaluate a pilot project for the Nutrition and Physical Activity Self-Assessment for Child Care (NAPSACC) intervention for preschool children in Corpus Christi.				X
3. Collaborate with the School Physical Activity Nutrition (SPAN) group to continue collecting data on demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th, 8th and 11th grade children.				X
4. Collaborate with Texas Tech University and the Lubbock Independent School District to analyze 25 years of school BMI data as it related to policy changes.				X
5. Explore collaborations with Baylor University School of Medicine, Division of Adolescent Health to develop and test innovative solutions to reduce adolescent obesity.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: WIC breastfeeding rates were approximately 70.7%. There was one Peer Counselor Training Workshop in the first quarter of FY2007 with a total of 21 participants. There were 22 Mini I Breastfeeding Workshops with a total of 503 participants. There were 7 Mini II Breastfeeding Workshops with a total of 189 participants. There were two Principles of Lactation Management (POLM) classes with a total of 149 participants. There was one Lactation Counseling and Problem Solving (LCAPS) class with a total of 37 participants.

Activity 2: Title V staff are continung efforts to carry out the activity, however it cannot be completed in FY07 and has been included in planned activities for FY08.

Activity 3: Family Health Research and Program Development staff have worked on the analysis of the previously collected SPAN data.

Activity 4: Texas Tech University and Title V have entered into a contract to complete this work.

Activity 5: A meeting has occurred between Baylor University School of Medicine, Division of Adolescent Health and Title V. The Texas Adolescent Health Coordinator and Child Health Coordinator attended several LEAH courses.

c. Plan for the Coming Year
Activity 1: Implement and evaluate a pilot project for the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) intervention for preschool children in Corpus Christi.

Output Measure: Work plan finalized; progress reports on activities related to the implementation and evaluation of a pilot project for the NAPSACC intervention in three to five childcare centers in Corpus Christi.

Monitoring: Review of quarterly progress reports relating to the activities and outcomes of the pilot project.

Activity 2: Collaborate with the School Physical Activity Nutrition (SPAN) group to continue collecting data on demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th, 8th and 11th grade children.

Output Measure: Prevalence of overweight among Texas school children by grade, gender and race/ethnicity; Analysis to identify sociodemographic, social, and mental health correlates of obesity.

Monitoring: Follow-up the development and implementation of SPAN.

Activity 3: Collaborate with Texas Tech University and the Lubbock Independent School District to analyze 25 years of school BMI data as it related to policy changes.

Output Measure: Analysis of the natural history of the obesity epidemic in Lubbock, Texas; Analysis of the impact of varying policies (e.g., introduction/elimination of vending machines, introduction of additional unhealthy food outlets, reductions in physical education requirements).

Monitoring: Quarterly status reports.

State Performance Measure 6: *The percent of children provided preventive dental services.*

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

Annual Objective and Performance Data	**2002**	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective					42
Annual Indicator				41.5	40.0
Numerator				1051633	1047804
Denominator				2532422	2620912
Is the Data Provisional or Final?				Final	Final
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	42.5	43	43.5	44	44.5

Notes - 2006
Source: TMHP, HISR303A, SFY 2006 Final (AHMST081).

Notes - 2005
Source: TMHP, HISR303A, SFY 2005 Final (AHMST081).

Data are for the State Fiscal Year (September - August).

Preventive services include all ADA preventive codes, D1000-D1999.

a. Last Year's Accomplishments
Activity 1: Establish and maintain five regional dental teams, which consist of one dentist and one dental hygienist then add an additional hygienist to each team over the next three years and then over the next five years.

Update: Regional teams currently consist of four dentists and five dental hygienists. The vacant dentist position in Region 9/10 is posted for hiring. DSHS staff is considering other funding opportunities to hire additional hygienists.

Through August 2006, regional oral health staff provided dental screenings to 18,442 school children and 5,865 (32%) of these school children received dental sealants. Regional oral health staff also provided screenings to 3,092 Head Start students and fluoride varnish to 3,073 (99%) of these students

Activity 2: Establish a state oral health coalition/collaboration and support for oral health prevention through water fluoridation and dental sealant.

Update: The Texas Oral Health Coalition (TxOHC) was established in November 2004 to focus on the priorities of early education and early intervention for the young child, identifying oral health issues for all populations, identifying opportunities, challenges and gaps in delivery of oral health services and raising awareness among legislators, the public and other groups about the need to improve access to care to oral health services. TxOHC elected officers wrote bylaws, established workgroups, mission and goal statements, and developed a coalition logo and website. TxOHC held quarterly meetings, including an annual Oral Health Summit. All of the coalition's activities and progress are tracked through an annual report in addition to the meeting minutes. In 2005, TxOHC successfully collaborated with the Children's Health Insurance Plan (CHIP) to help restore dental benefits under CHIP. In 2006, TxOHC collaborated with the DSHS Women, Infants, and Childrens (WIC) Program to develop and produce and oral health video and lesson plan for WIC clients.

Activity 3: Continue providing training to local water system operators, on-site inspections of system/equipment needs, and technical assistance to communities in need of fluoridation systems or upgrades.

Update: The Texas Drinking Water Fluoridation Project (TDWFP) program staff made seventy-one (71) inspection trips to public water systems that fluoridate from September 2005 through August 2006. Monthly report data are entered into the Centers for Disease Control and Prevention Water Fluoridation Reporting System (WFRS). The program continued to add, correct, and validate fluoridation data contained in the WFRS database, as the updated information was obtained. TDWFP held training classes in Bay City, Alice, Abilene, and Wichita Falls for water works operators with 29 water operators in attendance.

Performance Assessment: Forty percent of all children received dental sealants in 2006. A slight decline from 2005 (41.5%) and below the annual performance objective of 42%. With increases in the Medicaid reimbursement rates, activities implemented in FY06 require additional time before an accurate assessment of the impact can be made.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide dental services to third graders across the state enrolled in the free and reduced lunch program.			X	
2. Continue to support a state oral health coalition/collaboration to promote oral health prevention through water fluoridation and dental sealants.				X
3. Continue providing training to local water system operators, on-site inspections of system/equipment needs, and technical assistance to communities in need of fluoridation systems or upgrades.			X	X
4. Collaborate with multiple stakeholders to develop activities and materials to promote the dental home concept and early intervention to both providers and recipients of services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: DSHS regional dental teams provided dental screening services to 1,941 third graders and provided sealants to 747 (38%) third graders. During the first and second quarters of FY2007, the DSHS regional dental teams provided 9,147 eligible school children with dental screening services and 3,318 (38%) received dental sealants on at least one tooth. At multiple Head Start sites, 2,121 preschool children were screened and 2,271 received fluoride varnish treatments.

Activity 2: The Texas Oral Health Coalition (TxOHC) is entering its third year as a formal coalition. The TxOHC currently has 40 members from various entities. TxOHC held an annual general membership meeting on November 16, 2006

Activity 3: The Texas Fluoridation Project (TFP) program staff made 20 inspection trips to public water systems that fluoridate. TFP held three training classes in Beaumont, Athens and Texas City for water works operators with 30 water operators in attendance.

Activity 4: DSHS Oral Health Program staff, the Texas Dental Association, the Texas Academy of Pediatric Dentists, the Texas Dental Hygienists' Association, the Texas State Head Start Collaboration Office, and the ACF Region VI staff met in October 2006 and January 2007 to develop pilot activities to promote early intervention and the establishment of a dental home for children. Two meetings with 12 stakeholders were held between September 2006 and February 2007.

c. Plan for the Coming Year

Activity 1: Provide dental services to third graders across the state enrolled in the free and reduced lunch program.

Output Measure(s): Number of children served by regional dental teams or other entities.

Monitoring: Review and analysis of oral health data reports and screening survey reports.

Activity 2: Continue to support a state oral health coalition/collaboration to promote oral health prevention through water fluoridation and dental sealants.

Output Measure(s): Number and types of members on the Texas Oral Health Coalition (TxOHC) number of meetings held, number and description of activities addressed and/or achieved by the coalition.

Monitoring: Review and track progress through semi-annual activity reports of the TxOHC.

Activity 3: Continue providing training to local water system operators, on-site inspections of system/equipment needs, and technical assistance to communities in need of fluoridation systems or upgrades.

Output Measure(s): Number of training, on-site inspections, and technical assistance provided.

Monitoring: Review of and track progress through program quarterly activity reports and make necessary adjustments to the yearly plan.

Activity 4: Collaborate with multiple stakeholders to develop activities and materials to promote the dental home concept and early intervention to both providers and recipients of services.

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

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

State Performance Measure 7: *Rate of family violence incidents involving females victims per 1,000 women in Texas*

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					11.9
Annual Indicator				12.1	12.8
Numerator				136383	150602
Denominator				11268054	11734914
Is the Data Provisional or Final?				Provisional	Provisional
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	11.7	11.5	11.3	11.1	11.1

Notes - 2006
Provisional data are lagged one calendar year.

Source: http://www.txdps.state.tx.us/crimereports/04/cit04ch5.pdf from the Texas Department of Public Safety.

Notes - 2005
Provisional data are lagged one calendar year. Source: http://www.txdps.state.tx.us/crimereports/04/cit04ch5.pdf from the Texas Department of Public Safety.

a. Last Year's Accomplishments

Activity 1: Increase the number of successful referrals that occur as a result of screening for abuse in the Pregnant and Post-Partum Intervention Programs (PPI).

Update: Work continues on the design of Pregnant and Post-Partum Intervention Program (PPI) - specific module with the goal of implementing it in FY 2008.

Activity 2: Increase the number of successful collaborative activities to reduce violence against women in DSHS health service regions (HSRs).

Update: HSR 4/5N Social Work staff published/maintained resource directories for their service area which assist families in crisis. The public health nursing staff screened for partner violence at admit and annual family planning visits. Collaborations with local stakeholders included:

-Polk County Child Health Community Partnership -- free parenting classes with anger management and violence prevention
-Houston County Child Health Community Partnership -- weekly parenting classes weekly
-Mount Pleasant WIC Clinic -- weekly visit/presentation from counselor in the waiting room before nutrition classes.

HSR 6/5S worked with Liberty County in March 2006 to compile a resource list of domestic violence shelters and services available to citizens of Liberty County. On April 10, 2006, they presented a two-hour shaken baby education module to a community parenting class, which include participants developing a personal plan of action for times of stress. In May 2006, staff shared a list of shelters and available services with community members.

HHR 7 staff marked Child Abuse Month in April by presenting a high school program regarding date rape and drinking and driving prior (presented prior to Prom Night). They also made a presentation to City Council and Commissioner's Court on child abuse prevention, distributed personal care items to local shelters, met regularly with Rape Crisis Center staff, served on various local Domestic Violence Councils and Child Welfare Boards, screen every STD/HIV and pregnancy test client for domestic violence risks, worked with Highland Lakes Family Crisis Center to improve access to services and hosted and assisted with interpersonal violence training for community awareness. Regional staff also served on Community Resource Coordination Groups throughout the region.

HSR 8 staff participated in the Kendall County Child Service Board monthly meetings and activities. This group focused on special projects relating to child abuse, foster children and families, and domestic violence. In April 2006, they marked Child Abuse Prevention Month by hanging banners with a child abuse prevention message, "It shouldn't hurt to be a child" in the community and attended a candlelight vigil in Boerne remembering children who have been abused. Also in April, the service board members gave 3 presentations at 3 different school sites in Boerne to PTO groups and to school principles and the superintendent about recognizing child abuse and actions to take to report.

Activity 3: Develop and promote DSHS Web Page that focuses on Violence Against Women that is available to all public health providers. Included on this site will be a distance learning opportunity titled "The Prevention of Sexual Coercion Among Adolescents." Screening tools and information are also available.

Update: Changes in the Family &Community Health Services website delayed the posting of this information. Staff continued to work with Texas Association Against Sexual Assault and the Interpersonal Violence Prevention Collaborative to ensure that resources are provided through the listserv and to promote use of the listserv.

Performance Assessment: The rate of family violence involving female victims has experienced a slight decline between 2005 and 2006. The Texas Title V Program will continue to focus on

opportunities to provide education about preventing and recognizing domestic violence and partnerships with internal and external stakeholders to promote a more multifaceted approach to reducing this indicator.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase the number of successful referrals that occur as a result of screening for abuse in the Pregnant and Post-Partum Intervention Programs (PPI).			X	X
2. Collaborate with the Office of the Attorney General on a proposed cooperative agreement with the Centers for Disease Control and Prevention (CDC) to develop a Sexual Violence Prevention and Education program.				X
3. Estimate prevalence of family violence during and one year following pregnancy by integrating data from the Department of Public Safety and Vital Statistics.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Work continues on the design of Pregnant and Post-Partum Intervention Program (PPI) - specific module with the goal of implementing it in FY 2008.

Activity 2: Title V staff have attended three planning meetings regarding the sexual violence prevention planning committee and both of the official Primary Prevention Planning Committee (PPPC) meetings held in FY2007. To date, no materials have been developed. Staff are working with a subcommittee of the PPPC to develop a web-based survey to gain a better understanding of current practices and resources for primary prevention at the local level. This survey will be implemented in the summer of 2007. The Title V Women's Health Coordinator also serves on the steering committee for the Interpersonal Violence Prevention Collaborative (IVPC), a multi-agency effort to network, share resources and promote activities that will reduce interpersonal violence in Texas. This group has met approximately four times in FY2007.

Activity 3: This activity requires data linkages between Department of Public Safety records and the birth record. In the first half of FY07, the SSDI Governance Committee was established to facilitate data linkages. Title V staff are pursuing this data match in order to complete the analysis in the second half of FY07.

c. Plan for the Coming Year

Activity 1: Increase the number of successful referrals that occur as a result of screening for abuse in the Pregnant and Post-Partum Intervention Programs (PPI).

Output Measure(s): Number of women participating in PPI, number of women who answered yes to the PPI risk assessment question about abuse by family or significant others; number referred for domestic violence services; number for which a client consent and client consent follow-up form is completed and were monitored for client follow-through.

Monitoring: Review and document progress through bi-annual summary report of the PPI data.

Activity 2: Collaborate with the Office of the Attorney General on a proposed cooperative agreement with the Centers for Disease Control and Prevention (CDC) to develop a Sexual Violence Prevention and Education program.

Output Measure(s): Number of sexual violence prevention planning committee meetings attended by Title V staff; number and type of data and data analysis requests from the OAG completed; number and type of sexual violence prevention and educational materials developed and disseminated.

Monitoring: Minutes from quarterly sexual violence prevention planning committee meetings. Data reports.

Activity 3: Integrate family violence prevention professionals into State Child Fatality Review Team and local Child Fatality Review Teams.

Output Measure(s): Number of teams that include a family violence prevention professional; addition of family violence prevention professional to SCFRT as an ad hoc member.

Monitoring: Quarterly membership rosters.

Activity 4: Participate on the Interpersonal Violence Prevention Collaborative steering committee.

Output Measure(s): Number of meetings attended; implemented activities.

Monitoring: Meeting minutes.

E. Health Status Indicators

Second in size among the states, Texas has a land and water area of 268,581 square miles as compared with Alaska's 663,267 square miles. California, third largest state, has 163,696 square miles. Texas is as large as all of New England, New York, Pennsylvania, Ohio and North Carolina combined. Racially, Texas is primarily White with almost 7 times more Whites than African Americans. Ethnically, Texas has a significant Hispanic or Latino population. Among children 0 through 24 years of age, those of Hispanic or Latino descent accounted for 43% of the population.

/2008/ Among children 0 through 24 years of age, those of Hispanic or Latino descent accounted for 44% of the population. //2008//

Of the 50 largest cities in the country, 3 of the top 10 and 6 of the top 20 are located in Texas. This accounts for the more than 5 million children ages 0 through 19 who reside in urban areas. Almost 1.2 million Texas children ages 0 to 19 reside in rural areas with an additional 64,305 residing in frontier areas.

/2008/ More than 1.2 million children ages 0 to 19 years reside in rural areas with an additional 63,798 residing in frontier areas. //2008//

Proportions of residents living in poverty were greater among children 0 through 19 years of age than in the population in general. In the population, 36% of Texas residents are within 200% of poverty compared to 46% of children 0 through 19 years of age. Similar disparities were found for 50% of poverty and 100% of poverty.

Racially, the greatest number of births is to White mothers with nearly 10 times as many births as African Americans. Ethnically, Hispanic or Latino mothers account for slightly more than half (50.3%) of all births in Texas. Provisional data for 2005 projects continued consistency for several measures of birth outcome. In 2001, low birth weight among singletons was 6.1% with a projection for 2005 of 6.3%. The low birth weight rate in Texas is approximately 25% higher than the Healthy People 2010 objective of 5.0%. Very low birth weight has had similar consistency. Among singleton births in 2001, 1.0% had birth weight of less than 1,500 grams with a projection of 1.1% by 2005. The 2005 very low birth weight rate also is approximately 20% higher than the Health People 2010 Objective of 0.9%. Movement in this indicator contributes the monitoring of the impact of the 17 3-year population based contracts awarded in FY06 and FY07. While some of these contracts directly address low birth weight, the other topic areas addressed -- teen pregnancy, adequacy of prenatal care, and sexually transmitted diseases -- all contribute to low birth weight. Collaborations with March of Dimes (MOD) may also help to move this indicator. DSHS has used data from the Texas Pregnancy Risk Assessment Monitoring System (PRAMS) to inform the development of programs to improve birth outcomes among African Americans.

/2008/ The number of births to White mothers is approximately 8 times the number of births to African American mothers. Low birth weight among singletons is projected to be 6.4% in 2006, which is 28% higher than the Healthy People 2010 objective of 5%. Very low birth weight among singletons is projected to be 1.1% in 2006, which is 22% higher than the Healthy People 2010 objective of 0.9%.//2008//

Mortality rates due to unintentional injuries among children aged 14 years and younger are projected to decline in 2005 to 9.7 deaths per 100,000 children aged 14 years and younger. This would be a decline of 11% from the 10.9 deaths per 100,000 in 2001. Mortality rates due to motor vehicle crashes remained steady between 2001 and 2005. The projected rate in 2005 is 5.0 deaths per 100,000 children aged 14 years and younger. This projected rate would be 7.4% less than the rate of 5.4 deaths per 100,000 children aged 14 years and younger in 2001. While also consistent between 2001 and 2005, the mortality rate due to motor vehicle crashes was approximately 6 times greater in 15 through 24 year olds as compared to children aged 14 years and younger. The projected mortality rate due to motor vehicle crashes among youth 15 through 24 years old is 31.2 deaths per 100,000 youth ages 15 to 24 years, which is similar to the mortality rate of 31.1 deaths per 100,000 youth ages 15 to 24 years in 2001. With responsibility for the operations of the State Child Fatality Review Committee transferred to the Title V Office, assessment of data will be ongoing and findings expeditiously translated into prevention activities. This process may result in changes in these indicators.

/2008/In 2006, projected mortality due to unintentional injury decreased to 9.4 deaths per 100,000 children ages 14 years and younger; an almost 14% decline from 2001. The projected rate of mortality due to motor vehicle crashes declined slightly in 2006 to 4.9 deaths per 100,000 children aged 14 years and younger, a 9% decline from 2001. In 2006, the projected mortality rate due to motor vehicle crashes among youth 15 to 24 years old is 31.2 deaths per 100,000.//2008//

Rates of nonfatal injuries among children aged 14 years and younger have been inconsistent between 2001 through 2005. The 2005 rate of 234.7 nonfatal injuries per 100,000 children aged 14 years and younger is similar to the 2002 rate 226.7 nonfatal injuries per 100,000 children aged 14 years and younger, but substantially higher than the rates in 2003, 182.3 nonfatal injuries per 100,000 children aged 14 years and younger, and 2004, 174.2 nonfatal injuries per 100,000 children aged 14 years and younger. The nonfatal injury rate due to motor vehicle crashes in 2005 of 54.8 nonfatal injuries due to motor vehicle crashes per 100,000 children aged 14 years and younger was lower than rates in 2003 (74.2 per 100,000) and 2004 (63.9 per 100,000), but greater than rates in 2002 of 35.4 nonfatal injuries due to motor vehicle crashes per 100,000 children aged 14 years and younger. The rate of nonfatal injuries due to motor vehicle crashes per 100,000 were significantly higher among youth aged 15 to 24 years than children 14 years

and younger. Among youth ages 15 to 24 years, the rate of nonfatal injuries due to motor vehicle crashes is 209.2 per 100,000, four times greater than among children 14 years and younger. The rate in 2005 was the lowest since 2003. Between 2003 and 2004, the rate of nonfatal injuries due to motor vehicle crashes doubled to 224.4 per 100,000 and has continued to exceed 200 per 100,000. To improve this indicator, the Title V Office will conduct analyses of the Texas Hospital Discharge Data to identify trends in nonfatal injuries, compare these to mortality trends, and inform programmatic activities pertaining to prevention.

/2008/ Rates of non-fatal injuries in 2006 were higher than any rate reported in the past 5 years (240.8 nonfatal injuries per 100,000 children ages 14 years and younger). The nonfatal injury rate due to motor vehicle crashes in 2006 of 53.5 per 100,000 children ages 14 years and younger was the lowest since 2002. Among youth ages 15 to 24 years, the rate of nonfatal injuries due to motor vehicle crashes is 175.5 per 100,000, three times greater than among children 14 years and younger. The rate in 2006 was the first time this indicator was below 200 deaths per 100,000 since 2002. //2008//

Chlamydia rates have declined since 2001 among women ages 15 through 19 years, but have increased slightly among women 20 through 44 years during the same time period. In 2001, the rate of chlamydia among women ages 15 though 19 years was 29.0 cases per 1,000 which decreased to 25.8 cases per 1,000 in 2005. In 2004, the most recent year for which national surveillance data are available, Texas had a lower rate of chlamydia among women ages 15 through 19 years (26.2 cases per 1,000) than there was nationally (27.6 cases per 1,000). Among women ages 20 through 44 in Texas, rates of chlamydia ranged between 8.0 cases per 1,000 women ages 20 through 44 in 2001 to 8.5 cases per 1,000. The rate of chlamydia in Texas in 2004 (8.3 cases per 1,000) was higher than the national rate in the same age group (8.1 cases per 1,000).

/2008/ The rate of chlamyida infection among women ages 15 to 19 are projected to decline to 25.4 cases per 1,000 by 2006. For women 20 to 44 years of age, the projected rate in 2006 is the same as 2005 (8.5 cases per 1,000). //2008//

F. Other Program Activities

Sudden Infant Death Syndrome (SIDS): The Title V Program administers an autopsy reimbursement program mandated by Texas statute that allows counties to claim a fixed reimbursement toward the cost of an autopsy where the cause of death is determined to be SIDS. The program also provides a mechanism to track SIDS deaths, maintain a database that includes demographic information on the case and develop a better understanding of the circumstances that surround SIDS. In FY 03, Title V staff worked with a state-level workgroup to develop and present a workshop on infant mortality. A possible future activity for Title V staff is training stakeholders from areas with the highest incidence of SIDS.

Child Fatality Review: Texas has 46 local child fatality review teams (CFRTs) that review child deaths, identify gaps in service and agency coordination and develop community programs and activities to reduce the incidence of preventable child deaths. Data are collected and sent to DSHS for analysis, and aggregated data are used to identify statewide trends and prevention strategies likely to reduce preventable child deaths.

The Texas Child Fatality Review Team State Committee is charged with developing a better understanding of the causes and incidence of child deaths, promoting public awareness, making recommendations for changes in law, policy, and practices in order to reduce the number of preventable child deaths, and supporting the local CFRTs through technical assistance and networking. DSHS and the Department of Family and Protective Services (DFPS) jointly lead the State Committee. Legislation that passed during the 79th Texas Legislature moves the Committee leadership to DSHS. The feasibility of placing the Committee in the Title V program is being considered.

During the 79th Texas Legislature, there were discussions on creating a Fetal-Infant Mortality Review (FIMR) process. While the legislation did not pass, it is clear that information gained from a thorough, competent FIMR process enhances understanding of fetal and infant mortality and child deaths. DSHS staff are also looking at opportunities to integrate the FIMR process into the CFRT structure.

Toll-Free Hotline-2-1-1 Texas (2-1-1): As part of the HB 2292 Consolidation Act, many local and statewide health and human services toll free hotlines in Texas were centralized. The purpose was to minimize duplication, facilitate accessing information for the consumer, standardize the content and quality of the information provided, and reduce costs. Previously, Title V had multiple toll-free lines based on the various program areas including the Family Health Services toll-free line. In November 2004, most of the services provided by the Family Health Services toll-free hotline were transferred to 2-1-1 to provide callers with information about services offered by nonprofit and faith-based organizations and government agencies. The centralization of these lines enables consumers to easily access information. The service is provided through a public/private collaboration of the United Way and other community-based organizations and the Texas Health and Human Services Commission (HHSC). The state is divided into 25 Area Information Centers (AICs) that are networked to enable access to each other and to allow higher volume AICs to take calls for lower volume AICs as needed. The whole system can also mobilized to provide information and updates during times of emergency or during significant public health events.

/2007/ The responsibility for Child Fatality Review was officially integrated into the Title V Office in 2006, giving Title V staff the coordinating role for a group that can impact policies to reduce infant and child deaths. Due to the wide level of multidisciplinary stakeholder involvement from the CFRTs, DSHS gains extensive statewide information and support through this function. //2007//

The 2-1-1 line is available 24 hours a day, seven days a week and is accessible in multiple languages and by text telephone, or TTY. The language services are provided either by Tele-Interpreter or the AT&T Language Line. Title V and other DSHS staff routinely provide referral sources, such as contractors, to update the 2-1-1 database.

Referrals provided through 2-1-1 include assistance programs such as Medicaid, Medical Transportation, Food Stamps, TANF, WIC, Title V and other social services; service providers, including Early Childhood Intervention, immunization, substance abuse, mental illness, and mental retardation; Texas Special Education information; job training for persons with disabilities through the Texas Rehabilitation Commission; referral to licensed child-care facilities; resources for food, clothing, housing, education; and parenting classes.

As part of the transition, DSHS staff met with HHSC and 2-1-1 staff to review the capacity of 2-1-1. The decision was to continue a toll-free DSHS line so 2-1-1 could refer certain types of calls to DSHS. These calls include health screening programs and CSHCN.

From September to November 2004, 2,028 calls were received and 2,571 referrals were made through the Family Health Services line. After that, 2-1-1 became responsible for data collection. From December 2004 to May 2005, 2-1-1 handled 39,377 maternal and child health-related calls. The highest number of referrals was for medical expense assistance, followed by dental care and outpatient mental health care. This increase may be due to the simplicity of the number, the multi-lingual capacity, and the broader array of information and referral sources. The 2-1-1 System is growing through software enhancement and expanded data collection capabilities. Title V and 2-1-1 staff have collaborated to assure that Title V needs assessment data are routinely collected. //2007// Ultimately, 2-1-1 handled 60,755 maternal and child-health related calls in FY2005. In the first half of FY2006, 2-1-1 handled 50,281 maternal and child-health related calls. To date in FY2006, the highest number of referrals was for medical expense assistance, followed by

immunizations, dental care, outpatient mental health and local transportation.//2007//

National Women's Health Week (NWHW): Title V staff promoted the 2005 NWHW by informing contractors of the opportunity to develop activities focusing on women's health and serving as a resource for those who participated. Title V staff also worked with the Cardiovascular Health and Wellness Program to present an activity at DSHS.
/2007/ Title V staff coordinated NWHW again in 2006.//2007//

/2008/In 2007, the Women's Health Program began providing reproductive and women's health services to low-income women through a Medicaid waiver. Women who are citizens (or eligible immigrants) between the ages of 18 and 44, and who have a net income at or below 185% FPL can become eligible for the program. From January to April of this year, there were over 60,000 applications submitted and monthly enrollment figures have averaged nearly 39,000. DSHS staff continue to work with HHSC staff and DSHS contractors to provide outreach and referrals. Title V funds are used to serve women who are ineligible because of citizenship or who are under 18.//2008//

G. Technical Assistance

The population diversity, economy, and health needs of Texas continue to evolve in an environment for which resources continue to diminish, requiring an infrastructure that is effective and efficient. Consideration of the technical assistance needs described on Form 15 will enhance the state Title V program's efforts to meet the challenge of improving the health of the MCH population. Form 15 identifies the key areas for which Texas is requesting technical assistance.

Item 1 is related to NPM 9 for oral health. While nationally there is increasing recognition of the importance of early screening and referral for preventive care in the oral health of children, there remains a need to enhance access to such care. Currently, a limited number of pediatric and general dentists possesses the background and training to offer and/or provide this service. In Texas, practicing pediatric dentists are small in number and are concentrated in a limited number of urban counties. In order to meet the needs of young children, Texas requests technical assistance and funding to identify best practices related to providing and promoting preventive oral health care, including sealants, for children under 5, a plan for implementing training for providers on oral health screening/care to young children as well as enhancing awareness of caregivers regarding the importance of early preventive oral health care.

Items 2 and 3 are related to NPM 15, low birth weight infants and NPM 18, early prenatal care, specifically for the significant disparities that continue to exist for African American women. Although the Title V program activity plan for FY06 will target the population and areas of the state where low birth weights and low utilization of early prenatal care exist, Texas would benefit from technical assistance to identify low-cost yet effective strategies that would positively impact these two national measures and ultimately the outcome measures that continue to be a challenge. Those outcomes measures are infant mortality (OM #1), neonatal mortality (OM #3), perinatal mortality (OM #5), and, specifically related to the African American health disparity, the ratios of black infant mortality (OM #2) and perinatal infant mortality (OM #7) to that of whites. Texas data for these disparities mirror national data but there is no clear explanation for the disparities. However, research indicates that although early and adequate prenatal care is the primary approach to resolve the disparity, strategies designed to enroll and provide the care must meet the specific needs of the target population. Life Course Perspective is an evidence-based intervention model that specifically addresses this disparity by focusing on the overall health status of women, with special emphasis on the critical factors of inflammation, infection and stress. With technical assistance to design and implement this type of model, the Texas Title V program may be able to positively impact the health disparities in low birth weights and prenatal care for African American women.

Item 4 relates to improving the Texas Immunization Program's technical assistance materials

and methods. Improvement in this infrastructure could positively impact immunization rates in Texas (NPM 7) and ultimately all of the national and state outcome measures. The DSHS Immunization Program requests assistance in use of the program website as an effective technical assistance tool; for an external evaluation of customer service provision through the DSHS central office, the DSHS health service regions, and local health departments; and an external evaluation of publications used to provide technical assistance to the public, to healthcare providers, and to contractors around the state.

Item 5 is related to NPM 1 for newborn screening expansion. Pursuant to Legislation (House Bill 790) passed in the recently completed 79th Legislative Regular Session, DSHS will be looking to expand the panel of inheritable disorders screened in Texas. While expanding the screening, Texas also needs to consider the establishment of regionally-based contracts to assist with the follow-up, confirmatory testing and treatment of children who screen initially positive for the expanded list of disorders. Literature reviews indicate that often Title V is a source of additional funding to enhance newborn screening programs across the nation (Financing State Newborn Screening Systems in an Era of Change, Association of State and Territorial Health Officials, March 2005). Texas requests technical assistance resources to determine the feasibility of establishing regionally-based providers, educating them on the expanded disorders, and funding the follow-up, confirmatory testing and treatment of identified children in Texas.

/2007/ The population diversity, economy, and health needs of Texas continue to evolve in an environment for which resources continue to diminish, requiring an infrastructure that is effective and efficient. Consideration of the technical assistance needs described on Form 15 will enhance the state Title V program's efforts to meet the challenge of improving the health of the MCH population. Form 15 identifies the key areas for which Texas is requesting technical assistance.

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Items 2 and 3 are related to NPM 15, low birth weight infants and NPM 18, early prenatal care, specifically for the significant disparities that continue to exist for African American women. Although the Title V program activity plan for FY07 will target the population and areas of the state where low birth weights and low utilization of early prenatal care exist, Texas would benefit from technical assistance to identify low-cost yet effective strategies that would positively impact these two national measures and ultimately the outcome measures that continue to be a challenge. Those outcomes measures are infant mortality (OM #1), neonatal mortality (OM #3), perinatal mortality (OM #5), and, specifically related to the African American health disparity, the ratios of black infant mortality (OM #2) and perinatal infant mortality (OM #7) to that of Whites. Texas data for these disparities mirror national data but there is no clear explanation for the disparities. However, research indicates that although early and adequate prenatal care is the primary approach to resolve the disparity, strategies designed to enroll and provide the care must meet the specific needs of the target population. Life Course Perspective is an evidence-based intervention model that specifically addresses this disparity by focusing on the overall health status of women, with special emphasis on the critical factors of inflammation, infection and stress. With technical assistance to design and implement this type of model, the Texas Title V program may be able to positively impact the health disparities in low birth weights and prenatal care for African American women.

Item 4 relates to improving the Texas Immunization Program's technical assistance materials and methods. Improvement in this infrastructure could improve immunization rates in Texas (NPM 7) and ultimately all of the national and state outcome measures. The DSHS Immunization Program requests assistance in use of the program website as an effective technical assistance tool; for an external evaluation of customer service provision through the DSHS central office, the DSHS health service regions, and local health departments; and an external evaluation of publications used to provide technical assistance to the public, to healthcare providers, and to contractors around the state.

Item 5 relates to infrastructure improvements through increased public health and non profit leadership skills. Texas is currently one of the only states that does not have a public health leadership institute and is without access to a regional public health leadership institute. The creation of a Texas Public Health Leadership Institute would have two goals: 1) to enhance the leadership skills and abilities of senior and mid-level managers in state, regional, and local public health agencies and 2) to form a network of public health leaders in Texas and within Texas' public health regions. A Texas Public Health Leadership Institute would support the strengthening of leadership competencies, such as creating a shared vision, personal awareness, systems thinking, risk communication, team building, ethical decision making and political and social change strategies, which could contribute to improving the health of Texans through improved service delivery, efficiency, and strategic planning. Texas requests technical assistance resources to determine the feasibility and implementation plan of establishing a unique Texas resource for public health leadership development. //2007//

/2008/ There is a continued effort within the oral health program to seek out innovative practices that can be used to highlight the importance of early screening and referral for preventive care in the oral health of children. Texas continues to search for best practices related to providing and promoting preventive oral health care, including sealants for children under five; training options for providers on oral health screening/care for young children; and means of enhancing awareness of caregivers regarding the importance of early preventive oral health care.//2008//

/2008/In order to respond to direction to develop and fill a state position of parent consultant that must be filled by a parent or family member of a CSHCN, Title V staff are seeking an analysis of other states' policies and procedures related to similar positions and the corresponding employment criteria.//2008//

V. Budget Narrative

A. Expenditures

Forms 3, 4, and 5 show variations in expenditure amounts, which could be explained by the Title V budget realignment conducted for FY 02 and FY 03, directives from recent legislative sessions, the impact of CHIP, and the re-directing of Title V funds to accommodate specific MCH population needs.

Form 3 shows a variation in expenditures between FY 01 and FY 04. The expenditure level decreased from $107,287,294 in FY 01 to $85,078,798 in FY 04, representing about 21% variation. A portion of this decrease is attributed to a reduction in Title V state funds by an estimated of $7.8 million and $4.5 million in FY 02 and FY 03, respectively. This budget re-alignment effort was necessary because the Title V MCH program budgeted for services over and above the annual state and federal appropriations for some time. In addition, the 77th Legislative Session mandated Title V MCH and CSHCN programs to transfer state general revenue funds to CHIP and the Interagency Council on Early Childhood Intervention.

Form 3 also shows a carryforward of about $10 million from FY 05 into FY 06. One of many contributing factors could be the impact of CHIP. Expenditures on children between the ages of 1 and 22 vary greatly from $26,149,744 in FY 01 to $18,467,367 in FY04. Title V-funded contractors are required to screen children for potential Medicaid and CHIP eligibility prior to determining Title V eligibility and to spend at least 25% of their Title V amounts on children. Many of the contractors are experiencing difficulties in achieving the 25% requirement because a number of children who used to receive Title V child health services currently are covered by CHIP.

In addition, this carryforward could not be used alone to remove additional children from the CSHCN waiting list since this funding is available only one time. In other words, the CSHCN program could not sustain similar capacity to cover expenditures for all these children beyond FY 05. Another contributing factor is that the CSHCN program must notify the Legislative Budget Board and Governor at least 30 days prior to adding clients from the waiting lists to the program rolls. This mandated procedure has caused delays in moving children from the waiting list. Fortunately, the recently completed 79th Legislative Regular Session has changed the 30-day notification to 15 days, effective September 1, 2005.

The characteristics of the population served by the CSHSCN program contribute greatly in the significant variations in client expenditures from year to year. DSHS regularly analyzes the CSHCN Program client expenditures to operate within budget limitations. In FY 04, projected expenditures based on historical utilization data were greater than incurred costs to the state. As appropriate, funds were carried forward to FY 05 to allow additional children to be removed from the existing waiting list for the CSHCN Services Program's health care benefits. Projected costs vary due to differences in client access and utilization of third party coverage (i.e., Titles XIX, XXI, or private insurance); the wide array of possible diagnoses allowed within the eligibility criteria; and the unique medical needs of children with similar diagnoses.

Form 4 shows variations in the expenditures across MCH population types. Pregnant women, as well as infants under 1 year old, remain stable between FY 01 and FY 04. The expenditure levels between FY 01 and FY 04 are $ 18.1 million and $17.4 for pregnant women, and $188,643 and $170,750 for infants under 1 year old. These slight variations in expenditures for pregnant women and infants less than 1 year old can be attributed to the FY 02 & FY 03 Title V budget re-alignment.

Expenditures for CSHCN decreased from $41,346,111 in FY 01 to $29,608,981 in FY 04. This decrease can be attributed to two main raisons: 1) Title V was asked by the 77th Legislative Session to transfer one-time only $7 million in Title V funds to the Interagency Council on Early

Childhood Intervention (ECI), which provides a coordinated system of services available in every Texas county for children, birth through age 3, with disabilities or delays; and 2) CSHCN program was mandated by the same legislative session to commit state general revenues funds of $3 million in FY 02 and $10 million in FY 03 as savings acquired due to CSHCN being covered by CHIP and Medicaid programs.

Form 5 indicates significant variation in expenditures by types of service. As result of the decrease in total expenditures of $107,287,294 in FY 01 to $85,078,796 in FY 04, every category (i.e., direct health care services, enabling services, population-based services, and infrastructure building services) experienced decreases in expenditures. The rationale behind these expenditure variations was addressed in Forms 3 & 4 budget justifications.

/2007/ Forms 3, 4, and 5 show variations in expenditure amounts, which could be explained by the Title V budget realignment conducted for FY 02 and FY 03, directives from recent legislative sessions, the impact of CHIP, and the re-directing of Title V funds to accommodate specific MCH population needs.

Form 3 shows a variation in expenditures between FY 01 and FY 05. The expenditure level decreased from $107,287,294 in FY 01 to $83,872,474 in FY 05, representing about 22% variation. A portion of this decrease is attributed to a reduction in Title V state funds by an estimated of $7.8 million and $4.5 million in FY 02 and FY 03, respectively. This budget re-alignment effort was necessary because the Title V MCH program budgeted for services over and above the annual state and federal appropriations for some time. In addition, the 77th Legislative Session mandated Title V MCH and CSHCN programs to transfer state general revenue funds to CHIP and the Interagency Council on Early Childhood Intervention.

Form 3 also shows a carryforward of about $10.5 million from FY 06 into FY 07. One of many contributing factors could be the impact of CHIP. Expenditures on children between the ages of 1 and 22 vary greatly from $26,149,744 in FY 01 to $18,513,536 in FY05. Title V-funded contractors are required to screen children for potential Medicaid and CHIP eligibility prior to determining Title V eligibility and to spend at least 25% of their Title V amounts on children. Many of the contractors are experiencing difficulties in achieving the 25% requirement because a number of children who used to receive Title V child health services currently are covered by CHIP.

In addition, this carryforward could not be used alone to remove additional children from the CSHCN waiting list since this funding is available only one time. In other words, the CSHCN program could not sustain similar capacity to cover expenditures for all these children beyond FY 05. Another contributing factor is that the CSHCN program must notify the Legislative Budget Board and Governor at least 30 days prior to adding clients from the waiting lists to the program rolls. This mandated procedure has caused delays in moving children from the waiting list. Fortunately, the recently completed 79th Legislative Regular Session has changed the 30-day notification to 15 days, effective September 1, 2005.

The characteristics of the population served by the CSHSCN program contribute greatly in the significant variations in client expenditures from year to year. DSHS regularly analyzes the CSHCN Program client expenditures to operate within budget limitations. In FY 05, projected expenditures based on historical utilization data were greater than incurred costs to the state. As appropriate, funds were carried forward to FY 06 to allow additional children to be removed from the existing waiting list for the CSHCN Services Program's health care benefits. Projected costs vary due to differences in client access and utilization of third party coverage (i.e., Titles XIX, XXI, or private insurance); the wide array of possible diagnoses allowed within the eligibility criteria; and the unique medical needs of children with similar diagnoses.

Form 4 shows variations in the expenditures across MCH population types. Pregnant women, as well as infants under 1 year old, remain stable between FY 01 and FY 05. The expenditure levels

between FY 01 and FY 05 are $ 18.1 million and $17.8 for pregnant women, and $188,643 and $174,419 for infants under 1 year old. Children 1 to 22 years show a different trend. Expenditures dropped from $25,509,699 in FY 02 to $18,513,536 in FY 05.

Expenditures for CSHCN decreased from $41,346,111 in FY 01 to $29,565,393 in FY 05. This decrease can be attributed to two main reasons. First, Title V was asked by the 77th Legislative Session to transfer one-time only $7 million in Title V funds to the Interagency Council on Early Childhood Intervention (ECI), which provides a coordinated system of services available in every Texas county for children, birth through age 3, with disabilities or delays. Secondly, the CSHCN program was mandated by the same legislative session to commit state general revenues funds of $3 million in FY 02 and $10 million in FY 03 as savings acquired due to CSHCN being covered by CHIP and Medicaid programs.

Form 5 indicates significant variation in expenditures by types of service. As result of the decrease in total expenditures of $107,287,294 in FY 01 to $83,872,474 in FY 05, every category (i.e., direct health care services, enabling services, population-based services, and infrastructure building services) experienced decreases in expenditures. The rationale behind these expenditure variations was addressed in Forms 3 & 4 budget justifications. It is also important to note that direct care services (i.e., maternity, family planning, genetics, child health, dental care for children, dysplasia, and specialty services for CSHCN) represent about 70% of the total expenditures. Yet, the Title V program addresses only about 30% of the Title V eligible women and children in-need for health care services. //2007//

/2008/ Forms 3, 4, and 5 show variations in expenditure amounts, which could be explained by directives from recent legislative sessions, the impact of changes in CHIP eligibility, and the re-directing of Title V funds to accommodate specific MCH population needs.

Form 3 shows a variation in expenditures between FY 03 and FY 06. The expenditure level increased from $82,362,407 in FY 03 to $89,004,743 in FY 06, representing about 8% variation. A portion of this increase is attributed to the ongoing commitment of state funds in excess of the required Maintenance of Effort of 40.2 million. The state's investment in maternal and child health continues even in light of reduced federal awards from $39,496,620 in FY03 to $37,574,044 in FY06.

The estimated carryforward amount of $5,170,187 from FY07 to FY08 compared to the estimated $10.5 million from FY06 to FY07 demonstrates that Title V eligible individuals and families remain in need of maternal and child health services. The difference of almost $5 million was directed to Title V-funded contractors (health care providers) for the provision of services including: maternity, family planning, genetics, child health, dental care for children, dysplasia, and specialty services for CSHCN.

Form 4 indicates that the expenditures have increased from FY05 to FY06. While most expenditures remained stable across MCH population types, the CSHCN population shows an increase of $5 million. This can be attributed to availability of additional state funds and removal of children from the waiting list of the CSHCN Services Program in FY06.

Form 5 indicates slight variation in expenditures by types of service. As result of the increase in total expenditures of $82,362,407 in FY 03 to $89,004,743 in FY 06, direct health services and enabling services collectively increased by 7%. Population-based services and infrastructure building services remained relatively stable with an increase of less than 2% during the period. It is also important to note that direct care services (i.e., maternity, family planning, genetics, child health, dental care for children, dysplasia, and specialty services for CSHCN) represent about 67% of the total expenditures.//2008//

B. Budget

Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort (MOE) amount of $40,208,728. This represents more than $10 million in excess of the state matching rate of $3 state dollars for every $4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement
The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Title V contracts program requires all MCH Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a quarterly basis. Title V program leadership reviews reports and provides feedback as needed.

For FY 06, Form 2 shows that $11,272,213 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional $11,272,213 for children with special care needs. The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at $3,757,404, as shown in Form 2.

Other Sources of Funding for Women and Children
Texas receives other federal, state, and private grants related to women and children. These grants include: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - Integrated Comprehensive Women's Health Services; 4) MCHB - State Early Childhood Comprehensive Systems; 5) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 6) Support State Oral Disease Prevention Program; 7) Texas Cancer Council - regional school health specialists; 8) Title X State Coordinated Family Planning Project; 9) CDC Pregnancy Risk Assessment Monitoring System; 10) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 11) Chronic Disease Prevention and Health promotion- Obesity Component; and 12) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement.

Maintenance of Effort and Continuation Funding

/2007/ Texas will continue to provide the maintenance of effort (MOE) amount of $40,208,728. This represents more than $18 million in excess of the state match rate of $3 state dollars for every $4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement
The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Title V contracts program requires all MCH Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount. The Title V program funding

supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a monthly basis. Title V program leadership reviews reports and provides feedback as needed.

For FY 06, Form 2 shows that $10,559,197 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional $10,559,197 for children with special care needs. The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at $3,519,732, as shown in Form 2.

Other Sources of Funding for Women and Children
Texas receives other federal, state, and private grants related to women and children. These grants include: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - Integrated Comprehensive Women's Health Services; 4) MCHB - State Early Childhood Comprehensive Systems; 5) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 6) Support State Oral Disease Prevention Program; 7) Texas Cancer Council - regional school health specialists; 8) Title X State Coordinated Family Planning Project; 9) CDC Pregnancy Risk Assessment Monitoring System; 10) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 11) Chronic Disease Prevention and Health promotion- Obesity Component; and 12) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement. //2007//

Maintenance of Effort and Continuation Funding

/2008/ Texas will continue to provide the maintenance of effort (MOE) amount of $40,208,728. This represents close to $14 million in excess of the state match rate of $3 state dollars for every $4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement
The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Title V contracts program requires all MCH Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a monthly basis. Title V program leadership reviews reports and provides feedback as needed.

For FY 08, Form 2 shows that $10,562,125 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional $10,562,125 for children with special care needs. The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at $3,520,708, as shown in Form 2.

Other Sources of Funding for Women and Children
Texas receives other federal, state, and private grants related to women and children. These grants include, but are not limited to: 1) MCHB - State Systems Development

Initiative; 2) MCHB - Abstinence Education; 3) MCHB - Integrated Comprehensive Women's Health Services; 4) MCHB - State Early Childhood Comprehensive Systems; 5) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 6) Support State Oral Disease Prevention Program; 7) Texas Cancer Council - regional school health specialists; 8) Title X State Coordinated Family Planning Project; 9) CDC Pregnancy Risk Assessment Monitoring System; 10) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 11) Chronic Disease Prevention and Health promotion-Obesity Component; and 12) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement. //2008//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us
TDD: 512-458-7708

July 16, 2007

Title V Block Grant
HRSA Grants Application Center
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879

To Whom It May Concern:

As Assistant Commissioner of Family and Community Health Services for the Texas Department of State Health Services, I hereby submit this letter to apply for the Maternal and Child Health Services Block Grant funds for federal fiscal year 2008. The online application for Texas has been completed in accordance with this year's grant guidance.

Should you have questions or need additional information, please contact Dr. Fouad Berrahou or me at 512-458-7321.

Thank you for your consideration and review of the Texas' application for fiscal year 2007.

Sincerely,

Evelyn Delgado, Assistant Commissioner
Family and Community Health Services

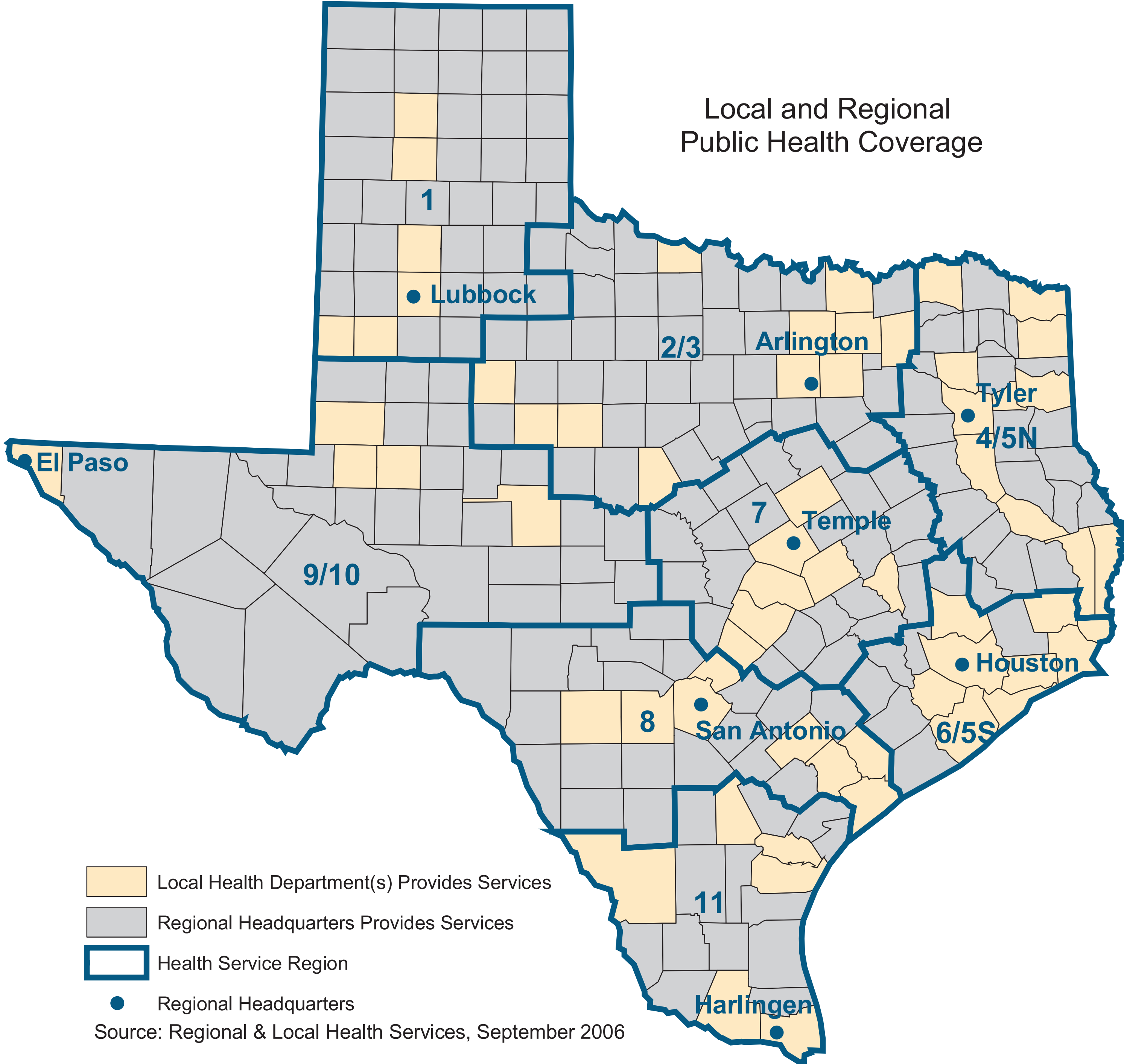
Attachment

Attachment II. C. Needs Assessment Summary

Additional Needs Assessment Activities

Hispanic Teen Pregnancy Prevention Summit - While rates of adolescent birth have declined since 1994, adolescent birth rates among Hispanic adolescents have remained relatively stable. In Texas, Hispanic adolescents comprise 42% of the adolescent population in 2007 and have the highest birth rate compared to other adolescents. This proportion is expected to increase to 47.6% by 2015, an increase of 125,000 adolescents. As reported in KIDS COUNT 2007, Texas has the highest rate of adolescent birth for ages 15 to 19 years. Title V staff has developed plans to convene local stakeholders from across the country to identify the essential components of effective adolescent pregnancy prevention within a culturally-appropriate Hispanic context. Details of the summit to be held in Austin on October 29th and 30th will be reported in the Annual Report for FY08 in the next MCH Title V Block Grant Application. (NPM 8)

Immunization Customer Satisfaction Survey - From June 29 to July 17, 2007, the Immunizations Branch of DSHS conducted a Customer Satisfaction Survey to obtain feedback from parents, legal guardians, vaccine providers and other professionals who access immunization information and services provided by DSHS. The Immunization Branch will use feedback received from the survey to improve immunization services in the coming year. (NPM 7)


Local and Regional
Public Health Coverage
1
Lubbock
2/3
Arlington
Tyler
4/5N
El Paso
7
Temple
9/10
Houston
8
San Antonio
6/5S
11
Harlingen
Local Health Department(s) Provides Services
Regional Headquarters Provides Services
Health Service Region
Regional Headquarters
Source: Regional & Local Health Services, September 2006

January – May 2007
80th Legislative Session Summary
Legislation Affecting the Department of State Health Services (DSHS)
Selected Bills Relating to Maternal and Child Health

The 80th Regular Session of the Texas Legislature ended on May 28, 2007, with a $51 billion budget approved for the state's five health and human service agencies for fiscal years 2008-2009 (FY08-09). Legislative action included reforms to Child Protective Services (CPS), Medicaid reforms to expand access to health coverage, and expanded funding for crisis mental health services.

CPS reforms include: increased rates for foster care; the addition of more than 1000 staff to oversee foster care placements; improved licensing and kinship support; and new "step-down" rate for psychiatric care of children with complex behavioral health needs.

Legislators provided funding to improve provision of preventive health services for children, including rate increases for physicians and dentists. Additional increases for Medicaid providers including long term care facilities were made. Senate Bill 10 provides direction to HHSC to focus additional reforms on prevention, emphasis on individual choice, maximizing available funds doe uninsured, and extending Medicaid coverage to children in foster care to age 23 if they are attending college.

Funding for the Children's Health Insurance Program (CHIP) includes increases to address caseload growth and the recent expansion to provide perinatal coverage. HB109 extends the CHIP eligibility renewal cycle from 6 months to 12 months, eliminates a 90 day waiting period, allows families to deduct child care expenses, and expands the asset limits for the program.

Legislators also provided funds to reduce the waiting and interest lists of multiple health and human services programs like the Medically Dependent Children Program, as well as the CSHCN Services Program.

Of the $5.2 billion appropriated by the Legislature to DSHS for FY08-09, about 43 percent is federal funds. New items for DSHS in the budget include the following:

$82 million for mental health community-crisis services.
$17 million to prevent, treat, and control the spread of tuberculosis and HIV.
$11 million to help Texas prepare for a flu pandemic.
$7.4 million to reduce waiting lists for children with special health care needs.
$5.2 million for an expanded Breast and Cervical Cancer Control Program.
$2.2 million to reduce waiting lists for children's mental health services.

Detailed description of bills impacting maternal and child health are included in the table below:

CHIP
HB 109 (Rep. Turner/ Senator Averitt) Relating to eligibility for and the administration of the child health plan program: HB 109 simplifies the eligibility process for the CHIP and repeals several policy changes that were enacted by the Legislature in 2003. The bill has no direct impact on DSHS. There is a provision that allows the Health and Human services Commission (HHSC) to delegate outreach activities to DSHS. However, an outreach contract between the HHSC and outside entity is already in place.
Prevention of Child Abuse and Neglect

HB 662 (Rep. Dukes/Senator Ellis) Relating to the coordination and improvement of certain programs and services for the prevention of and early intervention in child abuse and neglect: HB 662 expands the responsibilities of the existing Interagency Coordinating Council for Building Healthy Families by requiring the development of a long-range strategic plan for child abuse and neglect prevention services. The bill also requires the council to evaluate the potential for streamlined funding mechanisms and other issues related to existing programs and activities. DSHS will continue to participate as a member of the council.
Umbilical Cord Blood
HB 709 (Rep. Dukes/ Senator Ellis) Relating to information regarding umbilical cord blood options: HB 709 directs the HHSC to develop a brochure on umbilical cord blood options. DSHS anticipates that his responsibility will be delegated by the HHSC to DSHS. The brochure is to include information on current and potential use, risks and benefits of stem cells contained in cord blood to a potential recipient, options available for future use or storage of cord blood post delivery, the medical process used to collect cord blood, any risks associated with cord blood collection to mother or infant, and other information. DSHS will make the brochure available on the agency website and upon request to physicians or others permitted by law to attend a pregnant woman during gestation or at delivery.
Child Safety
HB 1045 (Rep. Truitt/ Senator Zaffirini) Relating to designating April as Child Safety Month: HB 1045 establishes April as Child Safety Month and increases public awareness regarding preventative measures needed to protect children. DSHS will coordinate child safety public education activities, such as Safe Rider and other traumatic brain injury prevention efforts, in conjunction with the designation of April as Child Safety Month.
Immunization
HB 1059 (Rep. Parker/Senator Nelson) Relating to an immunization awareness program in certain school districts: HB 1059 requires DSHS to prepare a list of required and recommended vaccines in English and Spanish for school districts to post on their websites. School districts must also post the locations of influenza vaccine clinics to the extent that they are known. The information must also include instructions for obtaining an exemption from the immunization requirements.
Immunization
HB 1098 (Rep. Bonnen/Senator Hegar) Relating to prohibiting immunization against human papilloma virus as a condition for admission to public school: HB 1098 prohibits the use of immunization against human papilloma virus (HPV) as a condition for admission to any elementary or secondary school and preempts all contrary executive orders. The law also requires the HHSC to provide educational materials regarding HPV that is unbiased, medically and scientifically accurate, and peer reviewed to parents or legal guardians at the appropriate time in the immunization schedule by the appropriate school.
Immunization
HB 1379 (Rep. Deshotel/Senator Nelson) Relating to human papilloma virus education programs: HB 1379 requires DSHS to produce and distribute informational materials regarding the human papilloma virus (HPV) vaccination. It also mandates inclusion of additional information regarding HPV in course materials related to sexually transmitted diseases in the model public health education program for school-aged children developed by DSHS.
Health Disparities
HB 1396 (Rep. Dukes/Senator Zaffirini) Relating to the Office for the Elimination of Health Disparities and the health disparities task force. HB 1396 transfers the Office for the Elimination of Health Disparities from DSHS to the HHSC. It also transfers the Health Disparities Task Force to the HHSC from DSHS and sets forth its purpose and duties.
Medicaid
HB 2042 (Rep. Dukes/Senator Nelson) Relating to an electronic database of physicians, hospitals,

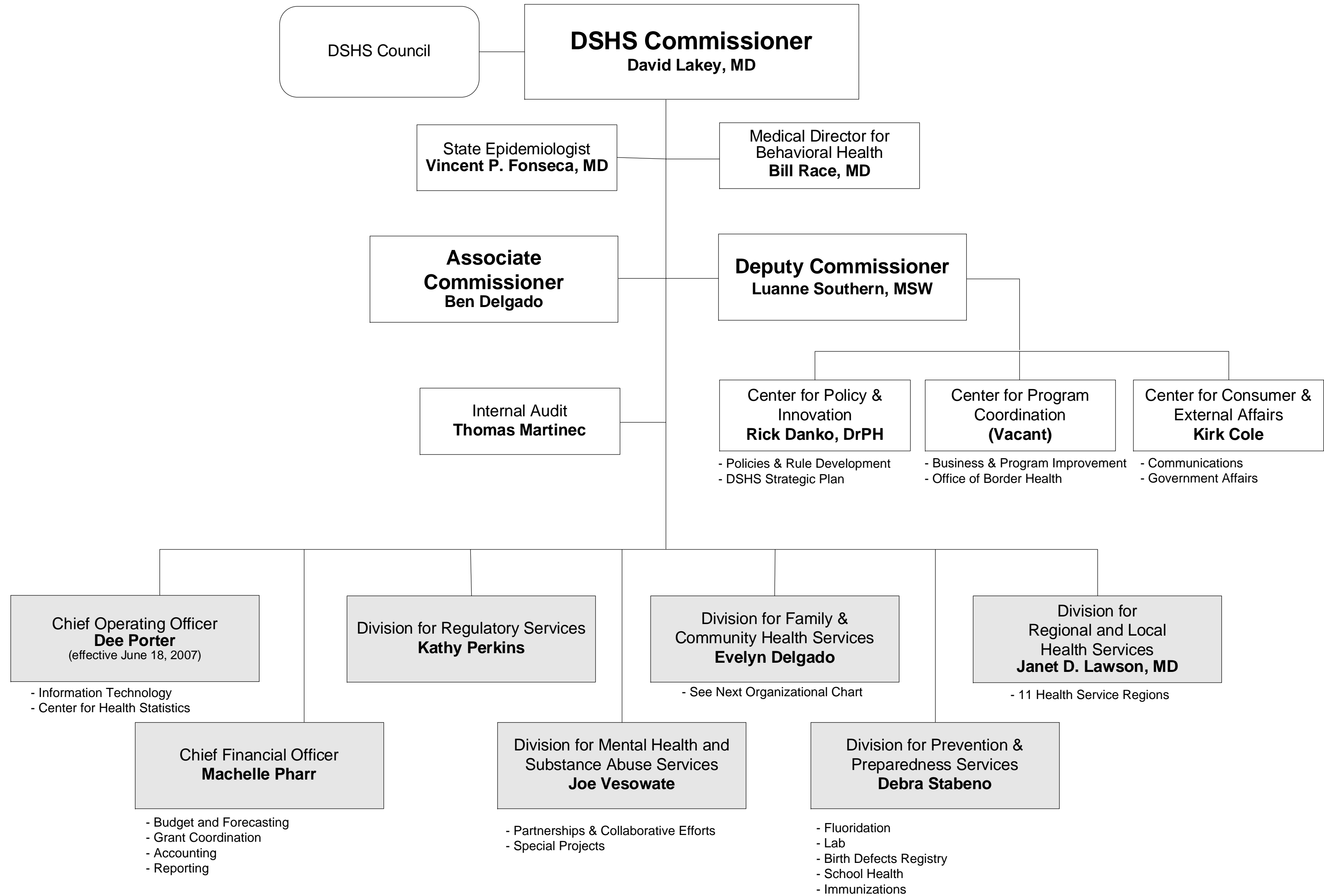
and other health care providers participating in the state Medicaid program: HB 2042 requires the HHSC to establish and administer an electronic, searchable, web-based database of all participating Medicaid providers. The database would include physicians, dentists, pharmacists, community clinics, mental health counselors, optometrists, and other types of Medicaid providers.
Persons with Disabilities
HB 2216 (Rep. Turner/ Senator Shapiro) Relating to the regulation of the sale of certain mobility motor vehicles equipped to transport a person with a disability: HB 2216 adds regulation of dealers who sell this kind of motor vehicle to the duties of the Texas Department of Transportation.
Obesity
HB 2313 (Rep. Rose/Senator Nichols) Relating to designating the second full week in September as obesity awareness week: HB 2313 designates the second full week in September each year as Obesity Awareness Week in Texas in order to raise awareness of the health risks associated with obesity and to encourage Texans to achieve and maintain a healthy lifestyle.
Behavioral Health
HB 2439 (Rep. Truitt/Senator Janek) Relating to the functions of local mental health and mental retardation authorities: HB 2439 addresses the roles and responsibilities of local mental health and mental retardation authorities, as amended by HB 2292 of the 78th Legislature. Provisions of the bill include: procedures DSHS must implement prior to making any changes to payment methodologies for mental health services during the next biennium; the establishment of a Local Authority Network Advisory Committee to advise DSHS on technical and administrative issues that directly affect local mental health authority functions and the activities to be performed by that committee; the responsibility of local mental health authorities (LMHAs) to develop a local network development plan, which is to be reviewed and approved by DSHS; the establishment by DSHS of an online best practices clearinghouse for LMHAs; a requirement for DSHS to assist an LMHA in attaining training and mentorship in using best practices established through the clearinghouse before removing an LMHAs authority designation; and conditions under which an LMHA may serve as a provider of services.
Immunization
HB 3184 (Rep. Coleman/Senator Deuell) Relating to the education of parents of young children about the benefits of vaccination against influenza: HB 3184 requires DSHS to publish online information for parents about the benefits of annual influenza immunizations and to work with the Department of Family and Protective Services and licensed daycare facilities to ensure the information is distributed to parents in a timely manner. It also requires the Executive Commissioner of the HHSC to conduct a study to determine the feasibility of implementing a system that gives priority for health care providers in the distribution of influenza vaccine.
Diabetes / Border Health
HB 3618 (Rep. Raymond/Senator Zaffirini) Relating to certain health programs and grants and other related funds for school districts located in the border region: HB 3618 requires DSHS, with funds appropriated for this purpose, to adopt criteria for the development of a pilot program designed to prevent and detect Type 2 diabetes. Certain border counties, as defined in the bill, may choose to participate in the pilot. HB 3618 also requires DSHS to employee one person to serve as a grant-writer to assist border region school districts in obtaining grants and other funds for school-based health centers. No funding specific to this legislation was included in HB 1.
Diabetes
HB 3735 (Rep. McReynolds/Senator Nichols) Relating to a diabetes demonstration pilot program: HB 3735 authorizes DSHS and the Texas Diabetes Council to create a diabetes pilot program at Memorial Health System of East Texas that would provide a comprehensive approach to promoting the prevention and treatment of diabetes and acanthosis nigricans. In addition, Memorial Health System of East Texas must submit a report to the Texas Diabetes Council regarding the effectiveness of the pilot program and any recommendations to continue, expand, or eliminate the pilot by October

1, 2008.
Medicaid
SB 10 (Senator Nelson/Rep. Delisi) Relating to the operation and financing of the medical assistance program and other programs to provide health care benefits and services to persons in this state: SB 10 primarily contains provisions designed to reform and expand the Medicaid program and to expand health coverage to uninsured persons. However, the bill also includes several provisions that impact DSHS. Among other provisions, SB 10: Returns Medical Transportation Program authority from the Department of Transportation to the HHSC; Allows tailored benefit packages for non-Medicaid populations; Establishes standards for and creates a workgroup to assess uncompensated hospital care reporting and analysis; Requires that any vehicle transporting a patient by stretcher to hold a licensed as an EMS provider; and Expands screening options and Medicaid treatment coverage under the Breast & Cervical Cancer Treatment Act.
Medicaid
SB 24 (Senator Nelson/Rep. Susan King) Relating to reimbursement under the state Medicaid program for certain health care services provided through telemedicine: SB 24 sets specific requirements relating to certain healthcare services provided through telemedicine. The bill also extends the current the HHSC telemedicine pilot until September 1, 2009, which allows community mental health centers to bill Medicaid for certain psychiatric services delivered via telemedicine links in certain rural and medically underserved areas.
Tobacco
SB 91 (Senator Van de Putte/ Rep. Zedler) Relating to point-of-sale health warnings for tobacco products: SB 91 requires point-of-sale tobacco signage to include certain text regarding the risk of smoking during pregnancy. The bill also authorizes the comptroller to accept gifts or grants to perform the duties under this section. DSHS is not involved with implementation of this bill.
Fetal & Infant Mortality Review
SB 143 (Senator West/Rep. Veasey) Relating to fetal and infant mortality review and health warnings related to fetal and infant mortality: SB 143 authorizes the creation of fetal and infant mortality review teams by a local health authority or official or DSHS. The bill specifies that the purpose of the review team is to improve the health and well-being of women, infants and families; reduce racial disparities in rates of fetal and infant mortality; facilitate the operations of the team; and develop and deliver reports of findings to the community. It also establishes the review team as a governmental unit and lists the specific duties of the team.
Nurse Family Partnership
SB 156 (Senator Shapiro/Rep. Madden) Relating to a competitive grant program to fund nurse-family partnership programs in certain communities in this state: SB 156 directs the HHSC to establish a competitive Nurse-Family Partnership (NFP) grant program. NFP is a nurse-based home visiting case management program that serves low income women in their first pregnancy and for two years postpartum. Although there are no specific mandates for DSHS, the HHSC will coordinate implementation with DSHS case management and Title V staff because of the potential overlap in populations served.
Physical Activity
SB 530 (Senator Nelson/Rep. Eissler) Relating to physical activity requirements and physical fitness assessment for certain public school students: SB 530 establishes minimum daily physical activity requirements for public school students and requires each school district to conduct an annual physical fitness assessment of all students in grades three through twelve. The Texas Education Agency's analysis of the physical fitness assessments will be reported to the statewide School Health Advisory Committee (SHAC), which is administratively supported by DSHS. The statewide SHAC is required to assess the effectiveness of coordinated school health programs, based on the analysis, and recommend modifications to such programs or related curriculum.

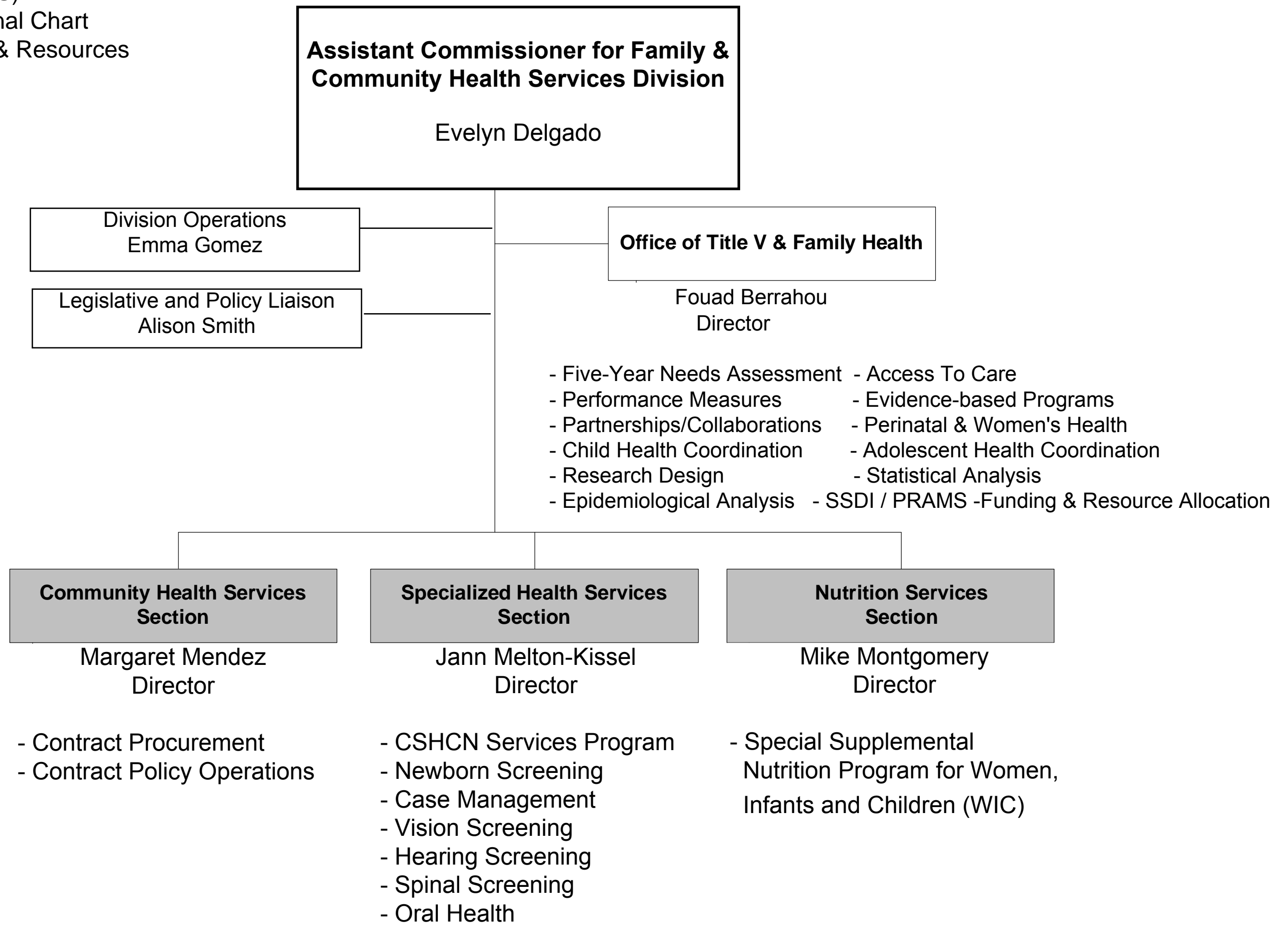
Obesity
SB 556 (Senator Lucio/Rep. McReynolds) Relating to the creation of an interagency obesity council: SB 556 requires the Commissioners of State Health Services, Agriculture and Education or their designees to meet at least annually to discuss the status of each agency's obesity prevention programs and consider the feasibility of tax incentives for employers who promote obesity prevention activities in the workforce. The bill also requires the agency representatives to submit a report and recommendations every odd-numbered year.
Child Safety
SB 680 (Senator Williams/Rep. Eiland) Relating to certain swimming pools as public nuisances in the unincorporated areas of counties: SB 680 adds a requirement that the fence securing a pool on abandoned property be locked and the pool covered. The bill allows counties to immediately secure an abandoned pool by installing a locked fence and a cover over the pool prior to the hearing process. It also allows counties to abate the nuisance posed by abandoned pools by installing a locked fence and cover or draining and filling the pool instead of demolition and removal. SB 680 does not affect DSHS regulatory authority.
Child Abuse and Neglect
SB 758 (Senator Nelson/Rep. Rose) Relating to child protective services: SB 758 contains numerous provisions affecting child protective services activities in Texas. However, there are two provisions related specifically to DSHS: The bill directs DSHS to implement an efficient and effective method of verifying birth information, or providing copies of certified birth records as needed for services provided to minors by the Department of Family and Protective Services and states that DSHS and the Department of Family and Protective Services will enter into a memorandum of understanding (MOU) to implement this section. The terms of the MOU will include methods for reimbursing DSHS for the actual costs of verifying the birth information or providing the birth record. The bill also specifies that a DSHS representative (preferably the agency's medical director) will chair the Committee on Pediatric Centers of Excellence Relating to Abuse and Neglect and establishes the responsibilities of the committee.
Child Fatality Review
SB 802 (Senator Nichols/Rep. Susan King) Relating to the child fatality review process, including the composition and functions of the child fatality review committee: SB 802 adds representatives of the Department of Public Safety and the Department of Transportation to the existing statewide Child Fatality Review Team. The bill also modifies membership terms and changes the due date for the annual report to allow sufficient time to compile relevant data.
Lead
SB 814 (Senator Janek/Rep. Dukes) Relating to environmental lead investigations by the Department of State Health Services: SB 814 gives DSHS the authority to conduct environmental lead investigations when the blood levels of a screened child are elevated. This bill also allows DSHS to adopt rules concerning follow-up care for children with elevated blood lead levels in a manner that is consistent with federal guidelines.

Attachment III. C. Organizational Structure

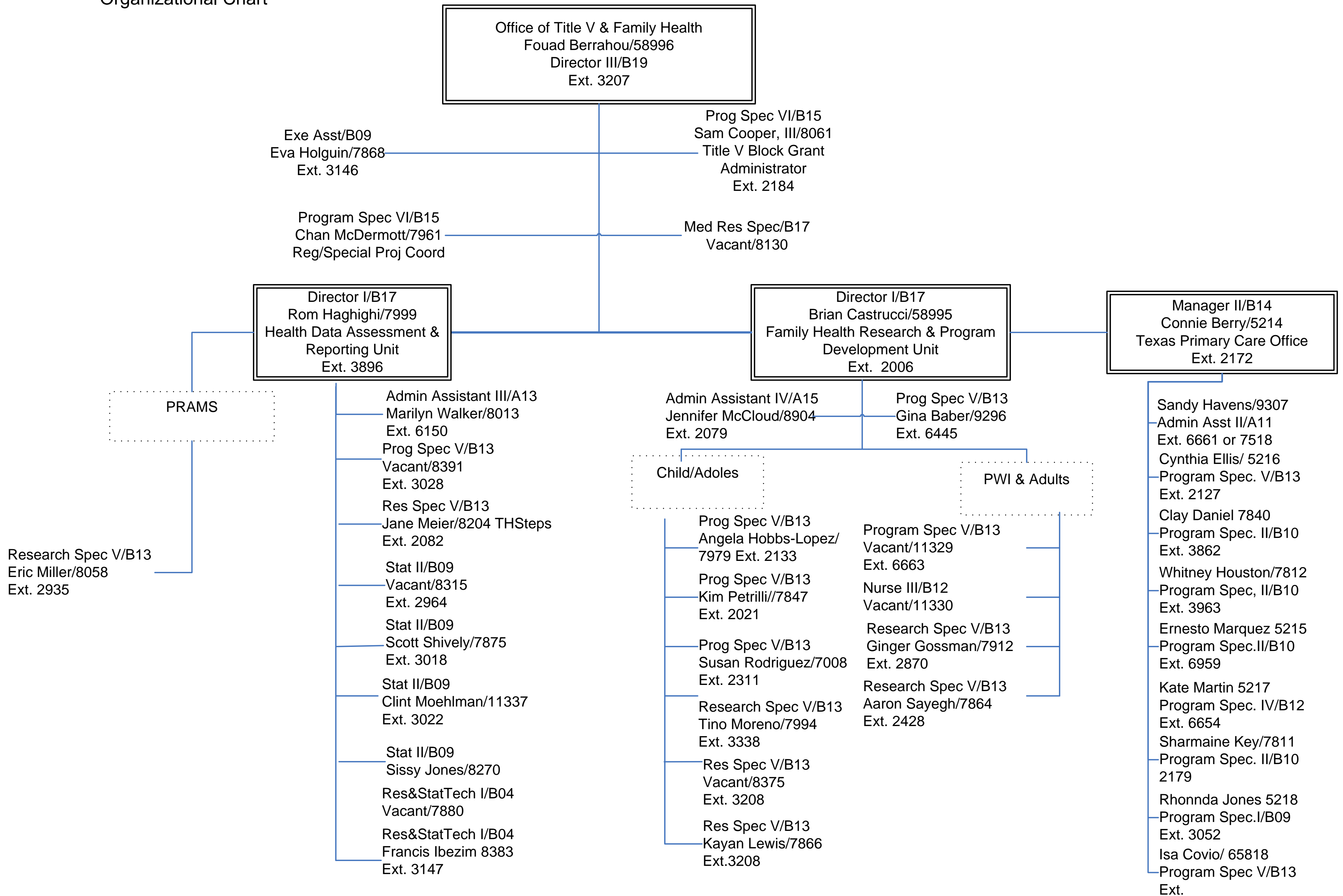
Department of State Health Services Organizational Chart
June 2007



DSHS Family & Community Health Services (FCHS) Organizational Chart Title V Support & Resources



DSHS Office of Title V & Family Health
Organizational Chart



July 1, 2007

Attachment III. C. Organizational Structure

Table 1: Number and Classifications of FTE personnel funded by the federal-state Title V Program (**FY 07**)

Table 1	
Job Description	Central Office
Accounting Technician	0
Administrative Asst	19
Attorney	0
Clerk	3
Data Base Administrator	1
Data Entry Operator	3
Director	4
Equipment Maintenance Tech	1
Executive Assistant	2
Financial Analyst	1
Information Specialist	3
Laboratory Technician	8
Manager	11
Medical Research	0
Medical Technologist	52
Microbiologist	8
Nurse	12
Nutritionist	0
Physician	3
Program Specialist	45
Program Supervisor	2
Programmer	0
Public Health Technician	21
Registered Therapist	1
Research & Statistics Tech	1
Research Specialist	2
Staff Services Officer	1
Statistician	2
System Analyst	6
System Support Specialist	0
Training Specialist	0
Total	214

Note: Within the positions listed in these tables, licensed social workers are employed in the state classifications of Manager, Program Specialists, and Human Service Specialists. The essential functions of the specific position determine whether the individual must be a social worker.

Table 2: Positions funded by federal-state Title V program by Health Service Region based on FY 07 data

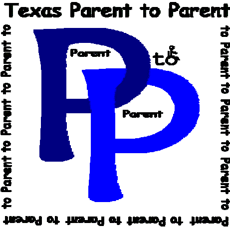
Table 2									
Job Description	HSR 1	HSR 2/3	HSR 4/5	HSR 5/6	HSR 7	HSR 8	HSR 9/10	HSR 11	TOTAL
Administrative Asst	3	7	2	9	3	4	8	5	41
Caseworker								0	0
Clerk			1	1	0	4	2	4	12
Dentist				1					1
Dental Hygenist				1					1
Epidemiologist		1							1
Human Services Specialist	2	4	9	6	1	3	2	3	29
Human Services Technician		0	4	2	8	7	6	4	31
Licensed Vocational Nurse							1	2	3
Manager	0	1	1	1	2	1	0	2	7
Nurse	2	3	10	9	5	9	8	4	50
Nurse Practitioner							2		2
Nutritionist			1						1
Physician			1						1
Program Administrator			0		0				0
Program Specialist	0	4	2	2	5	1	3	3	20
Public Health Technician		0	2		2	0		2	6
Receptionist								1	1
Total	6	20	32	32	25	29	32	29	205

Note: The numbers in all columns and rows are rounded to the nearest whole number.

Note: Within the positions listed in these tables, licensed social workers are employed in the state classifications of Manager, Program Specialists, and Human Service Specialists. The essential functions of the specific position determine whether the individual must be a social worker.

Texas Medical Home Toolkit

Texas Parent to Parent



The Texas Medical Home Toolkit was created through the collaboration of Texas Parent to Parent, the Texas Medical Home Workgroup and the Texas Department of State Health Services – Children with Special Health Care Needs (CSHCN) Services Program.

The development of this document was supported through a Champions for Progress Incentive Award from the Early Intervention Research Institute at Utah State University, funded by the Health Resources and Services Administration, Maternal & Child Health Bureau.

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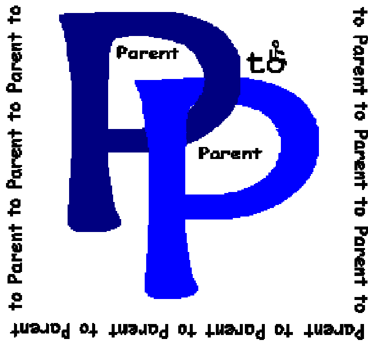

Texas Parent to Parent

Providing support and information for families of children with disabilities, chronic illness and other special needs

3710 Cedar Street, Box 12, Austin, TX 78705-1449
866-896-6001 512-458-8600
Website: www.txp2p.org Email: txp2p.org

Dear friends,

When I first heard the term Medical Home, my son was around 6 or 7 years old and was no longer medically fragile. I, like most parents I know, responded I didn't have a medical home any more since my son didn't need any medical equipment at home. The response I got helped me understand the term a little but 13 years later, Medical Home is still a vague concept. It's something I wish we had in place when my son was born at 24 weeks gestation.

The first 5 years were very difficult. If I had had one physician or clinic that truly helped me with all the specialists and decisions we were faced with those 5 years, I would have been thrilled. As it was, I was the one left to coordinate all the specialists, therapists, and insurance issues as well as make the necessary decisions about surgeries or treatments. And I had no medical background! I was the kid who hid under the bed when anyone even mentioned "doctor."

I see a Medical Home as what all parents dream of – the information and support from medical professionals as partners with the parent for those difficult decisions parents must make about their child with special needs. I can also see it as an excellent tool for physicians and clinics in working with and learning from parents that may help make some of the more difficult interactions run smoother. A parent who receives information, education, and support is a much happier and easier-to-get-along-with parent than one that has to fight for information or respect.

You have received this packet of information because you have expressed an interest in learning more about the concept of Medical Home and how to get one set up for your child or clients who have special health care needs. There is a lot of information in writing and on the Internet for medical professionals about Medical Home but not much can be found for parents. We hope this packet will start to fill that gap.

The Children with Special Health Care Needs (CSHCN) Services Program coordinates a Medical Home Workgroup that is developing materials and information to assist in making the medical home concept a reality for all children in Texas. We are in the process of establishing a listing of medical homes in Texas and need your help. If you currently have a medical home and/or if you are able to provide support to families seeking a medical home, please contact us so that we can add your information to our listing. With your help, we will create a listing of health care providers who are serving as medical homes in Texas to share with families who want to create one.

Please do us a favor by completing the enclosed survey and return it to us in the self-addressed stamped envelope. We will use your comments to improve the information provided.

Sincerely,
Laura J. Warren
Texas Parent to Parent

<u>What is a Medical Home</u>?
By Tammy Mann, Texas Parent to Parent

A Medical Home (MH) is a model of care delivery that your family should already be receiving. It is the end result of parents and health care professionals acting as partners. After all, you both want the same thing, right? Healthy children and families who are able to achieve their maximum potential. Unfortunately, most parents are not aware of what "medical home" means, most professionals think they already provide it, and the ones that don't are trying to figure out how to bill for it!

Medical Home is not the "term of the month." The definition was introduced in 1992 by the American Academy of Pediatrics. Their belief is "that all children should have a medical home where care is ***accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective."***

To be fair, health care professionals are not taught about Medical Home in school. Doctors learned to fix what was broken or bleeding, take out what didn't belong in, add in what was missing… but nowhere in the "rule book" was anything that said "play nice with the patient," never mind be ***"accessible,"*** make sure that you take all forms of payment (yes, that means insurance, Medicaid, Medicare, etc.), provide care in the family's community (not the big city 150 miles away), and make yourself available to speak directly to the families (and not after the family has left 10 messages). The MH model gives "bedside manner" a whole new meaning!

The best thing that a medical professional has ever said to me was that I know my child better than anyone. Well, if you think about it, that's true. Who knows our children better than we do? ***Family-centered*** care means just that - parents are the experts on their children, so why not be teammates with the health care professionals? In a true MH, recognizing that the family is the principal caregiver, the core, the one true constant in the child's life is just an extra tool for the provider. Nowhere else can you find a more reliable source for information.

Continuous means that you have the same health care professionals available from infancy through adolescence and young adulthood. AND, they assist with transitions including those to other pediatric providers or into adult health care systems.

Being able to access health care 24 hours a day, 7 days a week, 52 weeks a year should not be difficult if your health care provider has a ***comprehensive*** office. Hopefully, the preventive, primary, and tertiary (secondary) care needs are addressed in the office which should cut down on some of those "24 hour a day, 7 days a week, 52 weeks a year" emergency needs.

Providing resources falls into both ***comprehensive*** **and** ***compassionate*** services. Connecting families to support, educational, and community-based services only proves that the health care professionals understand and are working towards helping your family be the best they can be; it demonstrates concern for well-being, understanding and empathy.

The same can be said for being ***culturally effective.*** Professional translators or interpreters are great but truly understanding that a family's culture, beliefs, rituals, and customs are a part of the "whole" family, are the "frame work" of the family is critical and should be recognized, valued, and respected as families and physicians work together to develop a care plan.

Last, the family care plan should be ***coordinated***. It should be developed by the health care provider, child/youth, and family, and shared with other providers, agencies, and organizations involved with the care of the patient. Families are linked to support, educational, and community-based services and a central record containing all pertinent medical information (including hospitalizations, and other specialty care like outside therapies, etc.) is kept and maintained in a central record by the primary provider. This can be your pediatrician, family practitioner, or as in one family I know, your dermatologist.

Hopefully, this gives you a better understanding of what it means when someone says "Medical Home."

Additional Information on the "Medical Home"

- National Center for Medical Home Initiatives for Children with Special Health Care Needs Website: http://www.medicalhomeinfo.org
- Center for Medical Home Improvement http://www.medicalhomeimprovement.org The Medical Home Information Website: http://www.dshs.state.tx.us/cshcn/medhome.shtm
- Institute for Family Centered Care http://www.familycenteredcare.org/
- Institute for Child Health Policy http://www.ichp.edu/
- Academy for American Pediatrics http://www.medicalhomeinfo.org/tools/index.html
- The Texas Statutes for CSHCN Services Program http://www.capitol.state.tx.us/statutes/hs.toc.htm
- Parent to Parent http://www.p2pusa.org

REFERENCES

The Medical Home Policy Statement. Pediatrics. Elk Grove Village, IL: American Academy of Pediatrics; 2002. http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;110/1/184

The Children with Special Health Care Needs (CSHCN) Services Program (1-800-252-8023) http://www.dshs.state.tx.us/cshcn/benefits.shtm

Community Access to Child Health (CATCH) http://www.aap.org/catch/index.html

A Medical Home Means Family-Centered Health Care

A medical home:

Accessible	√ Provides community-based health care at times that best serve the community and the family. √ Accepts Medicaid, CHIP, CSHCN Services Program, and private insurance.
Family-Centered	√ Sees the family as the expert in their child's care. √ Offers a safe place for families and professionals to discuss health care issues as partners.
Continuous	√ Ensures that a child sees the same doctor over time. √ Provides transitional assistance to adult care or specialty care.
Comprehensive	√ Provides preventive, primary and specialized consultative care. √ Collaborates with specialists and therapists. √ Shares information about insurance and other resources.
Coordinated	√ Develops a plan of care with doctor, family, and child as a team. √ Offers support, education and links to schools and community based services.
Compassionate	√ Shows concern for child and family.
Culturally Competent	√ Acknowledges and respects every family's cultural and religious beliefs.

Providers Partner with Families in Medical Homes

Parent-professional teamwork is a key part of developing medical homes for all children.

What are families looking for in a health care provider?	√ A respectful listener √ Someone who sees their child as a "whole" person √ A caring attitude √ Understanding, support, and someone to be there for them √ Clinical know-how √ Someone who can add to their power and knowledge √ Someone who allows for and supports hope

"Our medical home is a place where they know my story, they listen to my son, and they respect us. They facilitate our services and recognize these service needs beyond medicine. They talk with us."

— Judie Walker, whose 18-year-old son has cerebral palsy and asthma

Adapted from ***What is a Medical Home?*** CSHCN Services Program, Texas Department of State Health Services stock no. 07-12153

Medical Home Checklist

Your child's pediatrician or family physician may not have all of the following pieces of Medical Home in their practice, but it will help to know what to ask for and what you can work on together. You can use this list when choosing a new physician for your child, or as a way to start a conversation with your child's doctor about Medical home.

Your child's primary care doctor and their office is accessible

- [ ] Available after hours, on weekends and holidays
- [ ] Accepts your child's health insurance
- [ ] Office and equipment physically accessible to your child

Staff within your child's primary care office know you and help you

- [ ] Know you and your child when you call
- [ ] Recognize and accommodate your child's special needs
- [ ] Respond to requests for prior approvals, letters of medical necessity for your child's insurance, or documentation for other programs and services
- [ ] Provide written materials in a language you understand

Your child's primary care doctor and office staff help you to coordinate your child's care.

- [ ] Follow up with difficult referrals
- [ ] Help you to find needed services such as transportation, durable medical equipment, home care, and ways to pay for them
- [ ] Explain your child's needs to other health professionals
- [ ] Reach out to your child's school or day care providers to help them understand your child's medical condition
- [ ] Encourage and support frequent communication between all persons involved in your child's care (with your consent)
- [ ] Organize and attend team meetings about your child's plan of care that include you and other providers

Your child's primary care doctor respects you and listens to your observations about your child.

- [ ] Asks you to share your knowledge about your child
- [ ] Seeks your opinion when decisions are needed
- [ ] Talks to you about how your child's condition affects your family (other children in the family, child care, expenses, work, sleep)
- [ ] Acknowledges and respects your family's cultural values and religious beliefs
- [ ] Provides interpreter services if needed

Your child's primary care doctor and office staff work with you to plan your child's care.

- [ ] Help you set short-term (3-6 months) and long-term (the next year) goals for your child
- [ ] Give you important information, such as recommendations or new treatments, in writing
- [ ] Work with you to create and update a written plan of care for your child's medical and non-medical needs
- [ ] Review your child's medical records with you when needed
- [ ] Help you consider new and emerging treatment choices for your child's condition

Your child's primary care doctor and office staff support you as a caregiver.

- [ ] Help you connect with family support organizations and other parents in your community
- [ ] Provide information on community resources
- [ ] Find and share new information, research or materials that are helpful in caring for your child
- [ ] Help you to advocate on behalf of your child
- [ ] Plan for adult health care services (if appropriate for your child's age)

Adapted from **A NEW WAY…A BETTER WAY**. The Medical Home Partnership: Building a Home Base for Your Child with Special Health Care Needs: New England SERVE http://www.neserve.org/neserve/med_hm.html

NATIONAL, STATE, AND LOCAL INITIATIVES TO PROMOTE MEDICAL HOMES

The federal Maternal and Child Health Bureau has established a national performance measure that all children with special health care needs will receive regular, ongoing, and comprehensive care within a medical home.

The Texas CSHCN Services Program receives funding from the federal Title V Maternal and Child Health Block Grant and is responsible for helping to achieve this national performance measure in Texas. The CSHCN Services Program rules state that each program client should receive care in the context of a medical home. The CSHCN Services Program coordinates a Medical Home Workgroup that is developing materials and information to assist in making the medical home concept a reality for all children in Texas. For additional information on the Medical Home Workgroup, call 512-458-7111, x3026 or 800-252-8023 (toll-free) or email cshcn@dshs.state.tx.us.

The American Academy of Pediatrics (AAP) promotes the "medical home" as best practice. The AAP's "Medical Home Policy Statement" notes that the provision of a medical home is cost effective, ensures quality of care, and can lead to improved health outcomes through an identified primary source of care. The AAP's medical home website (http://www.medicalhomeinfo.org/tools/index.html) is a valuable resource for additional information on the AAP medical home initiative.

Several sites in Texas are implementing a family centered, community based, training program that focuses on educating physicians-in-training about CSHCN and their families. The innovative curriculum brings doctors out of the hospital and into the home to learn first-hand from the family's perspective and offers a curriculum for teaching physicians and other professionals the key health care services and resources necessary for children and adults with special health care needs to live in the community. The following is a list of contacts for information on the Texas area physician training programs:

Austin, Temple, Dallas or Fort Worth	Debbie Wiederhold Texas Parent to Parent Network (512)458-8600 / debbie@txp2p.org
Houston	Elaine Hime (713)926-2580 / projectDOCCHouston@yahoo.com
San Antonio	Chris Tucker (210)292-3566 / christie@c-a-m-p.org
Corpus Christi	Marie Soza (361)851-9255 / msoza@5tx.rr.com

<u>Steps to Becoming a Parent Partner in Your Physician's Office</u>

By Tammy Mann, CSHCN Medical Home Learning Collaborative

Hopefully, you already have a doctor you feel provides family-centered care! But if not, your first step will be to locate a new doctor! If you need assistance with locating one in your area, The American Academy of Pediatrics Pediatrician Referral Service (herein after called AAP Pediatrician Referral Service) is intended for use by the general public to allow them quick access to information on pediatricians.

If you are looking for a pediatrician who specializes in the care of children with disabilities and/or children with developmental or behavioral issues, you can use the Pediatrician Referral Service to search for a pediatrician by specialty. You can also search on a website for a pediatrician by last name, city, state, zip code or area code at www.aap.org/referral/.

Another option, and my favorite, is to contact Texas Parent to Parent (www.txp2p.org) and see if they have any physician referrals from parents in your area of Texas. The important thing to remember is that just because a doctor is on someone's referral list does not mean that you will approve of them.

Okay, so you have a doctor; it does not have to be the pediatrician, it could be the sub-specialist (neurologist, orthopedist, cardiologist, dermatologist, etc.) that you feel is the doctor who coordinates your child's care, the one who keeps up with all the other things going on with your child in order to make sure that he/she receives ***continuous, comprehensive, and coordinated care.***

If it is a physician you have been working with for a while, you may feel comfortable giving him/her the Medical Home Brochure and asking what you can do to help his office become more involved. Of course, this is after you have expressed your appreciation for all the wonderful care your child has received over the years.

However, just like everything else in our lives, it is easier if you have ideas of ways you can "help" the office become more family-friendly, provide families with much needed information, help the office run smoother, and even SAVE the office $$$$. The latter is a very important point because cost is usually one of the first responses from the office manager or physician as to why things cannot be changed.

The American Academy of Pediatrics believes in the philosophy of Medical Homes for all children because not only does it enhance the quality of care a family receives, it also enhances the overall effectiveness of the practice. The AAP has developed a link on their website that covers the reimbursement arena for practices.

The following is a list of a few ideas to help you get started.

1. Ask your child's doctor if some of the family-centered things he/she does could become more general practice. Suggest that the office organize a meeting of parents, staff, and providers to talk about how to improve services for families like yours.

2. One thing that has been discussed in meetings is accessibility: How easy is it for you to get to your appointment?
    a. What could make it easier?
    b. When you get to the office, is parking available?
    c. Can you put a wheel chair lift down and get a person in a wheelchair out of the vehicle in the space provided?
    d. Are the doors electric?
    e. Does a staff member help you get in?
    f. Is there ample space in the office for a person in a wheelchair?
    g. How long is the wait time?
    h. How difficult is the wait time for you and your child?
    i. Is there enough time during the actual visit?
    j. Is there some sort of code to alert the appointment desk to schedule extra time during the visits of patients with special needs?

3. Offer to set up a Parent Resource and Networking Bulletin Board in the office. This may sound like a lot of (free) work and it can be but it does not have to be! TxP2P's website has a Resource Directory that is regularly updated and printable. Are there meetings in your area? If so, put it on the board too! Remember to keep the board current.

4. If there are parent meetings in your area, maybe some of the information would be helpful to the office staff - invite them to attend the meetings.

5. Invite the physician to speak at one of the meetings or maybe the office would like to host a "Parents Night." There are numerous topics that could be a possibility (disability specific topics, potty training, behavior, transitions, resources, etc.).

6. Does your child have a Care Plan? How about an Emergency Room Information Sheet? A positive point to stress is that if the patient goes into the ER with an Emergency Care Plan, they will not have to contact the physician in the middle of the night when their patient shows up!

If you have a care plan, discuss it with your doctor, let them help you make sure the information on it is really what a stranger would need to know about your child to provide the proper care. Offer to share your plan with other "patients" in the office; this could also be another topic for a parent meeting.

You may even be able to get your local emergency department to host or sponsor such a meeting because of the valuable information the plan would provide them. If you do not have a care plan, you can search the internet or go to the AAP website at www.medicalhomeinfo.org/tools/care_notebook.html, contact Texas Parent to Parent, or contact the CSHCN Services Program office at the Department of State Health Services, 1100 West 49th St, Room 442, Austin, TX 78756, www.dshs.state.tx.us/cshcn/default.shtm or call the CSHCN Services Program Inquiry Line at 1-800-252-8023.

Medical Home Resources
Presented by Beverly MacCarty & Tammy Mann
Texas Parent-to-Parent Annual Conference - July 2005

The medical home Web site contains resources, information, and tools on providing medical homes for children and youth with special health care needs (CYSHCN). Visit this site to learn more about CYSHCN, the providers and families that care for them, and the strategies that practices, communities, and states are taking to improve the lives of CYSHCN.

The National Center of Medical Home Initiatives for Children with Special Needs provides support to physicians, families, and other medical and non-medical providers who care for children with special needs so that they have access to a medical home.

American Academy of Pediatrics
The National Center of Medical Home Initiatives
for Children with Special Health Care Needs
http://www.medicalhomeinfo.org/

The National Center of Medical Home Initiatives
141 Northwest Point Blvd
Elk Grove Village, IL 60007
ph: (847) 434-4000 fax: (847) 228-7035

Information is also available in Spanish: http://www.medicalhomeinfo.org/tools/spanishportal.html

Tools

For Families	For Youth	For Communities and States
√ Bright Futures	√ When/Where to Start	√ Links to other programs
√ Care Notebooks	√ After High School	**For Insurers**
√ Communication Tips	√ Post Secondary Schooling	√ CYSHCN: Data
√ Future & Estate Planning	√ School To Career	√ Benefits of Medical Home
√ Insurance Information	√ Programs and Resources	√ Focusing in on the Workplace
√ Internet Tips		√ Guides and Toolkits
√ School Forms & Resources		√ Model Programs

For Health Care Providers

√ Care Plans/ Assessments	√ Insurance/ Managed Care
√ Coding for CSHCN	√ Medical Home Measurements
√ Communication Tips	√ Palliative Care
√ Documentation Guidelines & Sample Forms	√ Physician Operations Manual
√ Emergency Medical Resources	√ Referral Forms
√ Hospital & Discharge Forms	√ Surveys for the Office
√ Identifying CSHCN	

Training Programs and Materials

Every Child Deserves a Medical Home Training Curriculum http://www.medicalhomeinfo.org/training/

Screening Initiatives

National Center Surveillance and Screening Activities - The National Center of Medical Home Initiatives for Children with Special Needs engages in many types of surveillance and screening activities including hearing, vision, developmental and newborn metabolic/genetic screening.

Partnerships with the Maternal Child Health Bureau, Centers for Disease Control and Prevention's National Center for Birth Defects and Developmental Disabilities and the Federal Department of Education, allow the National Center to promote the natural role of surveillance and screening within quality primary care. Information contained on these pages aims to assist you with incorporating continuous surveillance and structured screening into the medical home you provide or is provided to your child.

Grant and Funding Opportunities

- MCHB Medical Home and Integrated Service Grantees
- CATCH Medical Home Planning Grants

Medical Home Mentorship Program

http://www.medicalhomeinfo.org/model/

The Medical Home Mentorship Program offers guidance, resources, and networking opportunities for individuals, communities and states to assist them in achieving increased access to medical homes. The success of the program relies heavily on the continued efforts of state, community, and practice-based medical home teams to share their strategies, lessons learned, tools, and resources designed to improve the delivery of care to CYSHCN.

Department of State Health Services – CSHCN Services Program/Medical Home home page:

http://www.dshs.state.tx.us/cshcn/medhome.shtm

- Medical Home Fact Sheet
- Medical Home Brochure – Spanish and English
- Medical Home Workgroup

Center for Medical Home Improvement:

www.medicalhomeimprovement.org

The mission of the Center for Medical Home Improvement is to establish and support networks of parent/professional teams to improve the quality of primary care medical homes for children and youth with special health care needs and their families. Useful tools, assessments, and resources are available on this site.

MedHome Portal:

www.medhomeportal.org

The MedHome Portal is a web-based resource aimed at providing primary care physicians with ready access to information, tools, and services to improve their care and coordination of care for their patients with special needs

Oregon Medical Home Web site:

http://cdrc.ohsu.edu/oscshn1/medicalhome/index.html

This site contains general information about the medical home and educational materials and resources to support families of CSHCN, health care providers and other community professionals such as teachers and early intervention professionals. Their primary purpose is to make these supports available to the pediatric practices and medical home resource teams who are partners in the Oregon Medical Home Project.

***Primer on the Illinois Medical Home Model for Physicians*:**

http://internet.dscc.uic.edu/medhome/mdprimer/MHPhysicianPrimer.asp

The first two components of the Illinois Medical Home Model define what it means when families say they have a Medical Home and what it means when physicians say they provide a Medical Home. The third component describes the activities occurring in Illinois to promote the Medical Home Model. The primer includes references, video clips, PowerPoint presentations and many handouts that are downloadable. Also included is the 2nd edition of the UIC-DSCC Medical Home CME Monograph for community pediatricians and family physicians that was published on May 1, 2004. The entire 70 page document is downloadable as a PDF file.

Primer on the Illinois Medical Home Model for Families:

http://internet.dscc.uic.edu/medhome/familyprimer/FamilyMHPrimer.asp

"What Families Need to Know about a Medical Home" has been developed to explain the Medical Home Model for families and children with special health care needs. It explains the family-professional partnership and how it relates to accessing quality health care. The primer goes on to explain how families can become proactively involved in Quality Improvement Teams in their primary care provider's practice. There are links to the AAP web site describing what others states are doing to promote Medical Home, a downloadable Parent-Partner Guide, Power Point presentations, and information about the Illinois Title V CSHCN Program

Special Needs Resource Directory of Southwest Ohio:

www.cincinnatichildrens.org/svc/alpha/c/special-needs/resources/default.htm

The Center for Infants and Children with Special Needs at Cincinnati Children's Hospital Medical Center has created an extensive, one-stop resource directory to assist caregivers of children with specialized health care needs. The goal of the Special Needs Resource Directory is to provide comprehensive web-based information -- assembled in one convenient location -- to both parents and professionals. The directory includes information on issues related to advocacy, assistive technology, clinical trials, community services, dental care, education, employment, estate and future planning, financial assistance, guardianship, home health care, mental health, MR/DD services, nutrition resources, summer programming, therapies, transition issues, transportation, and wish-granting organizations.

Washington State Medical Home Web Site:

www.medicalhome.org/

Use this website to find successful strategies and practical medical home tools developed for busy families and professionals.

- Families: Find strategies and tips to develop a partnership with your child's physician, organize your paperwork, advocate for your child, take care of yourself, and other tips from parents who've "been there."

- Physicians: Find diagnosis-specific care guidelines, patient education materials, printable lists of community services by county for children with special needs, reimbursement options, coding tips and office management strategies.

- Other Medical Home Partners: Find referral forms and strategies to improve communication with primary care physicians, tips on how to empower families to become more effective medical home partners and advocates for their children and more.
- Links to other community, state and national resources and services

TelAbility: ***www.telability.org/index.pl***

An innovative, community oriented, interdisciplinary program that uses telecommunications to improve the lives of children with disabilities. Using real time video-conferencing and internet technologies, TelAbility provides comprehensive, coordinated, family centered care to children with disabilities across North Carolina and offers education, training, and peer support for people who care for them.

Working with Other Related Programs

Early Intervention (Part C of the Individuals with Disabilities Education Act -IDEA)

http://www.dars.state.tx.us/ecis/index.shtml

Early Childhood Intervention (ECI) is a statewide program for families with children, birth to three, with disabilities and developmental delays. ECI supports families to help their children reach their potential through developmental services. Services are provided by a variety of local agencies and organizations across Texas.

National 211

2-1-1 is an easy to remember telephone number that connects people with important community services and volunteer opportunities While services that are offered through 2-1-1 vary from community to community, 2-1-1 provides callers with information about and referrals to human services for every day needs and in times of crisis. For example, 2-1-1 can offer access to the following types of services:

- Basic Human Needs Resource: food banks, clothing closets, shelters, rent assistance, utility assistance.
- Physical and Mental Health Resources: health insurance programs, Medicaid and Medicare, maternal health, Children's Health Insurance Program, medical information lines, crisis intervention services, support groups, counseling, drug and alcohol intervention and rehabilitation.
- Employment Supports: financial assistance, job training, transportation assistance, education programs.
- Support for Older Americans and Persons with Disabilities: adult day care, congregate meals, Meals on Wheels, respite care, home health care, transportation, homemaker services.
- Support for Children, Youth and Families: childcare, after school programs, Head Start, family resource centers, summer camps & recreation programs, mentoring, tutoring, protective services.

You can find out more about your state 211 Program at: http://www.211.org/status.html

Web Resources for Services & Information

Texas Parent to Parent: www.txp2p.org

Statewide program that provides support, information, resources, one on one matching, quarterly newsletter, resource database, trainings, technical support and much more to families that have children with disabilities, chronic illness, or other special needs and the professionals that work with those families.

Children With Special Health Care Needs (CSHCN) Services Program:

http://www.dshs.state.tx.us/cshcn/default.shtm

The CSHCN Services Program website provides information on programs, rules, laws, legislative issues, family supports, transitions, medical homes and much more.

Child and Adolescent Bipolar Foundation: http://www.bpkids.org/
Very informative resource for individuals of all ages dealing with bipolar and their families.

Disability Resources on the Internet: http://www.disabilityresources.org/index.html
Disability Resources Monthly's guide for cutting through the morass of disability-related material on the Web.

Exceptional Parent: http://www.eparent.com/
EP's on-line resource site containing information, support, ideas, encouragement & outreach for parents and families of children with disabilities, and the professionals who work with them.

Family Village: http://www.familyvillage.wisc.edu/index.htmlx
Welcome to the Family Village! We are a global community that integrates information, resources, and communication opportunities on the Internet for persons with cognitive and other disabilities, for their families, and for those that provide them services and support. Our community includes informational resources on specific diagnoses, communication connections, adaptive products and technology, adaptive recreational activities, education, worship, health issues, disability-related media and literature, and much, much more!

Internet Resources for Special Children: http://www.irsc.org/
This site covers a wide variety of topics from I & R, clothes, recreational sports, home schooling, to guide dogs, and employment!

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Medical Home Toolkit
Evaluation

Please give us your opinion of the Medical Home Toolkit you just reviewed. By sharing your opinions, you can help us make this a more effective document. Your input will be used to improve the toolkit, so please be candid.

Please tell us how accurately the statements below reflect your views by filling in the appropriate bubble.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The Medical Home Toolkit was well organized.	○	○	○	○	○
2. The Medical Home Toolkit was useful to me.	○	○	○	○	○
3. The Medical Home Toolkit provided information that was new to me.	○	○	○	○	○
4. I feel I have more information to take to my child's doctor about the help I need from him/her.	○	○	○	○	○
5. I have a better understanding of the concept of Medical Home.	○	○	○	○	○
6. I currently have a medical home for my child/family.*	○	○	○	○	○
7. I can provide support to families who would like to have a medical home.*	○	○	○	○	○

Please use the space below to share any thoughts or suggestions you have to improve this document.

____

____

____

____

*We would like to have information from you to create a listing of health care providers who are serving as medical homes in Texas to share with families wishing to create one. Please contact us at 866-896-6001 (toll-free) or "Medical Home" http://www.txp2p.org/. Thanks!

A Simulation Model of Teenage Pregnancy Risk in Texas: 2005 to 2015

MA Sayegh PhD MPH, BC Castrucci MA, A Hobbs-Lopez DO, F Berrahou PhD
Family Health Research & Program Development Unit, Office of Title V & Family Health,
Texas Department of State Health Services

Introduction

From 1991 to 2003:

- The pregnancy rate among Texas women:
  - 13 to 17 decreased from 29.1 to 26.
  - 15-19 years: 125.4 to 101.1
- These rates remain the highest teenage pregnancy rates in the industrialized world.
- Population projections predict dramatic change in the demographic characteristics of Texas' residents, not only in size but also in composition.

Objective

- To use changing population characteristics, and rates of sexual activity and contraception to project teen pregnancy risks from 2005 to 2015.

Methods

Data

- Texas Birth Records from 1991 to 2003
- Office of State Demographer Projections
- YRBS Data
- Contraceptive Failure Rates
  - (Santelli et al 2003) and Family Planning Data

Sample

- Adolescent women in Texas ages 15 to 19 who gave birth between 1991 and 2003

Model Construction

- Numerical Projections in Crystal Ball
- Simulation Model in STELLA

Parameter Estimates

- Rate of Natural Increase
- Weighted Average Contraceptive Failure Rate (WACFR)
- Sexual Activity
- Pregnancy Rates (Abortion + Fetal Deaths)

Methods

Measures

Women 15 to 19 from 1991 to 2003:

Natural Increase

- Annual Growth
  - All Adolescent Women: +1.7%
  - White Women: -0.11%
  - African American Women: +1.3%
  - Hispanic Women: +4.4%
  - Other: +1.7%

Sexual Activity

- Annual Growth
  - All Adolescent Women: - 0.5%
  - White Women: -0.4%
  - African American Women: - 0.8%
  - Hispanic Women: +0.3%
  - Other: - 0.7%

Weighted Average Contraceptive Failure

- Annual Growth
  - All Adolescent Women: - 0.5%
  - White Women: -0.4%
  - African American Women: - 0.8%
  - Hispanic Women: +0.3%
  - Other : - 0.7%

Pregnancy

- Annual Growth
  - All Adolescent Women: - 0.02%
  - White Women: - 0.02%
  - African American Women: - 0.03%
  - Hispanic Women: -0.02%
  - Other: -0.03%

Methods (continued)

Analyses

- Numerical Projections from 2003 to 2015 for rates using Monte Carlo simulation.
- Simulation Analysis for Pregnancy Risk based on stochastic process and logistic function.

Results

Figure 1: Natural Increase

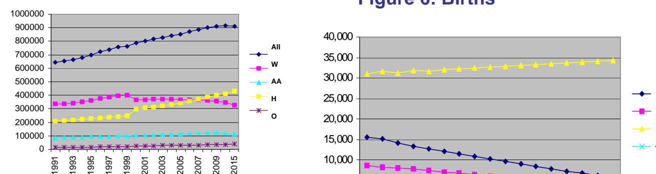


Figure 2: Sexual Activity

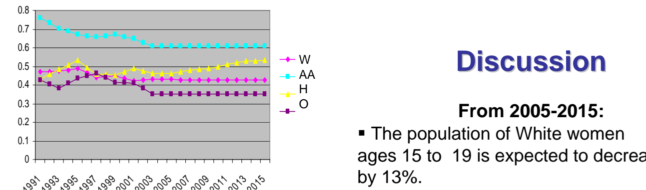


Figure 3: WACFR

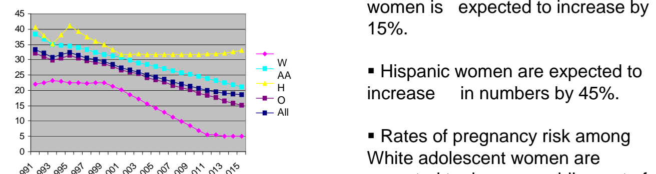
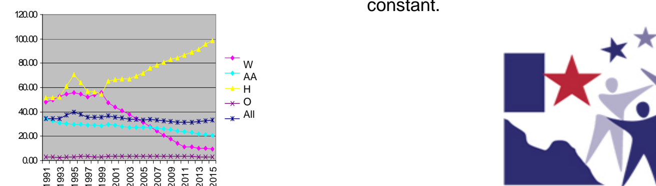


Figure 4: Pregnancy Risk



Results (continued)

Figure 5: Pregnancy Rates with Intervention

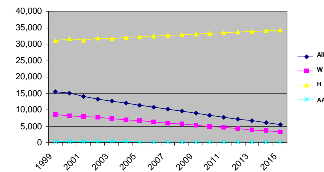
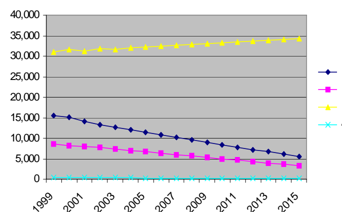


Figure 6: Births



Discussion

From 2005-2015:

- The population of White women ages 15 to 19 is expected to decrease by 13%.
- The number of African American women is expected to increase by 15%.
- Hispanic women are expected to increase in numbers by 45%.
- Rates of pregnancy risk among White adolescent women are expected to decrease while a rate for African American adolescent women is expected to remain relatively constant.

Discussion (continued)

By 2015:

- Hispanic pregnancy risk rates for women ages 15 to 19 are expected to increase by 12%.
- The expected pregnancy risk rate for teenage women ages 15 to 19 in Texas is expected to increase from 32.5 to 57.4 per 1000.
- If preventions/interventions efforts are implemented, pregnancy rates may reach 53.5 per 1000 for women 15 to 19.

Conclusion

- Overall pregnancy rates have been declining among Texas teenagers over the past decade.
- Changing population characteristics, differential rates of sexual activity and contraceptive failure among racial sub-populations will affect pregnancy risk.
- The population of teenage women most at risk for pregnancy will increase substantially.
- Public health assistance services need to be aware of the implications of changing population characteristics.
- Pregnancy prevention efforts and targeted outreach programs need to be intensified.

Contact : aaron.sayegh@dshs.state.tx.us

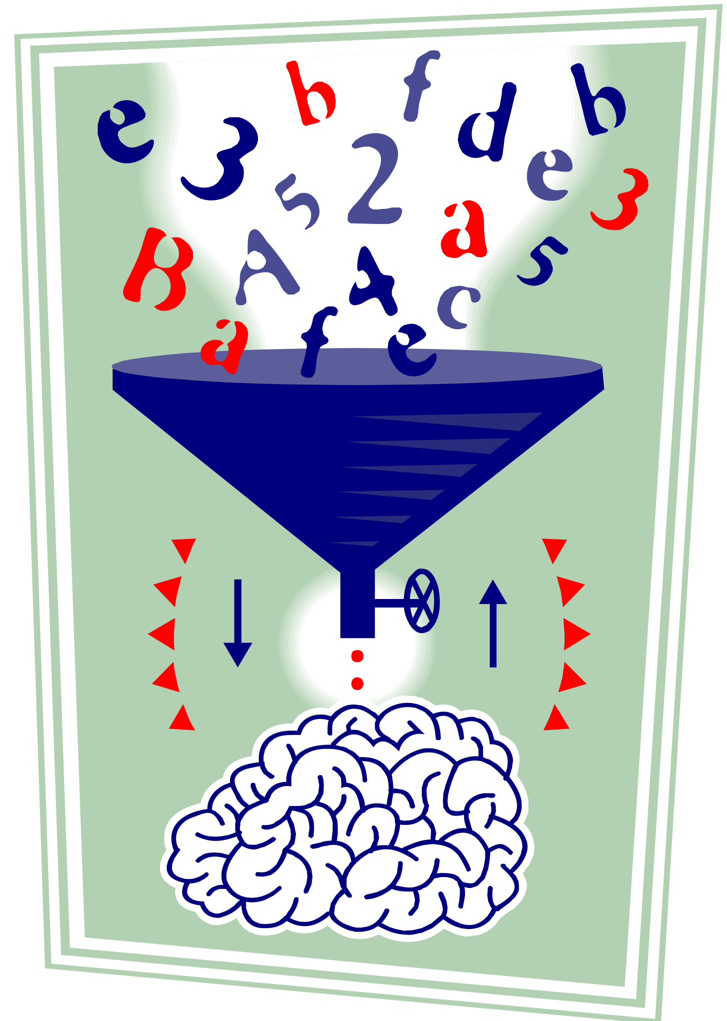
Perinatal Periods of Risk Snapshot

Location: Houston, TX

Attachment IV. C. NPM8

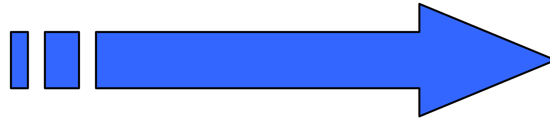
Data Parameters

- Linked infant birth and death certificates
- Infant and fetal deaths >500 grams
- Infant and fetal deaths >24 weeks gestation



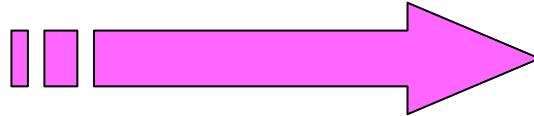
Birthweight	Fetal Death	Neonatal <28 d	Post- neonatal ≥28 d
500 g - 1499 g	Maternal Health/Prematurity		
1500+ g	Maternal Care	Newborn Care	Infant Health

Maternal Health/ Prematurity



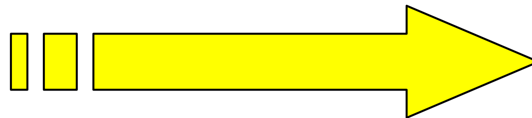
Preconception Health
Health Behaviors
Perinatal Care

Maternal Care



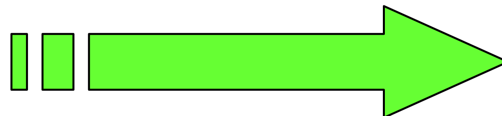
Prenatal Care
High Risk Referral
Obstetric Care

Newborn Care



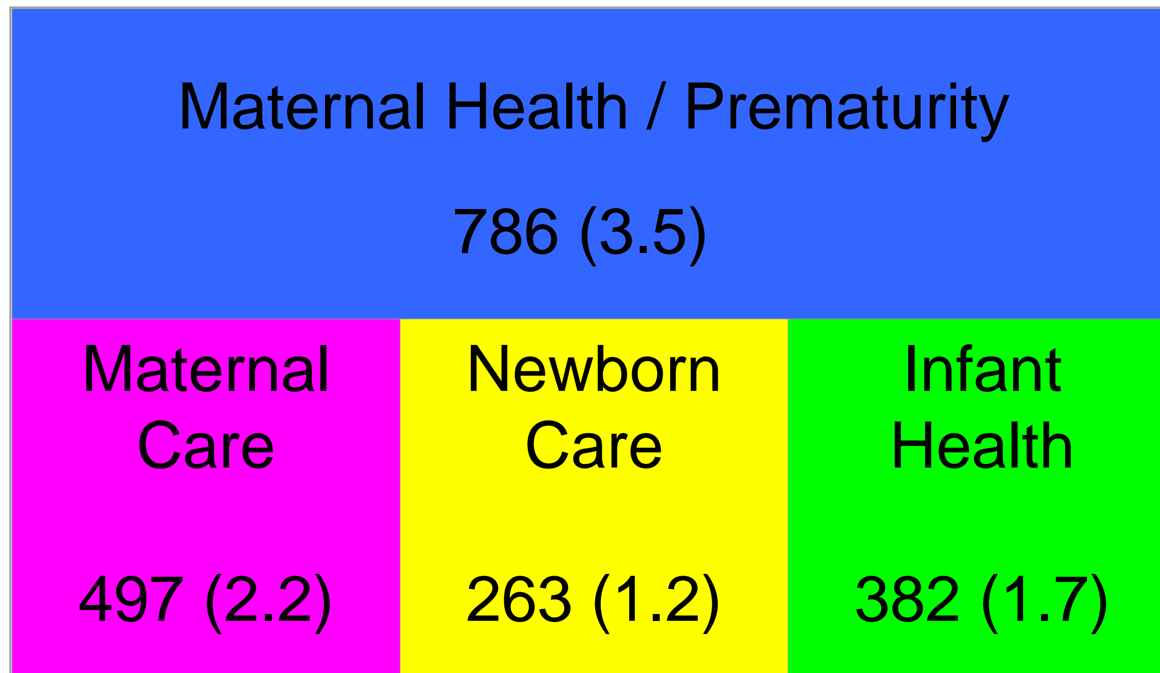
Perinatal Management
Neonatal Care
Pediatric Surgery

Infant Health



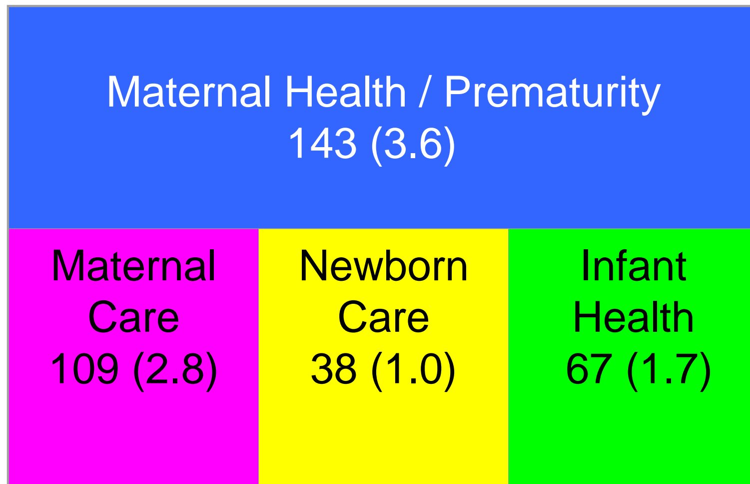
Safe Sleep
Breast Feeding
Injury Prevention

Houston Feto-Infant Mortality Rate, 1999-2003

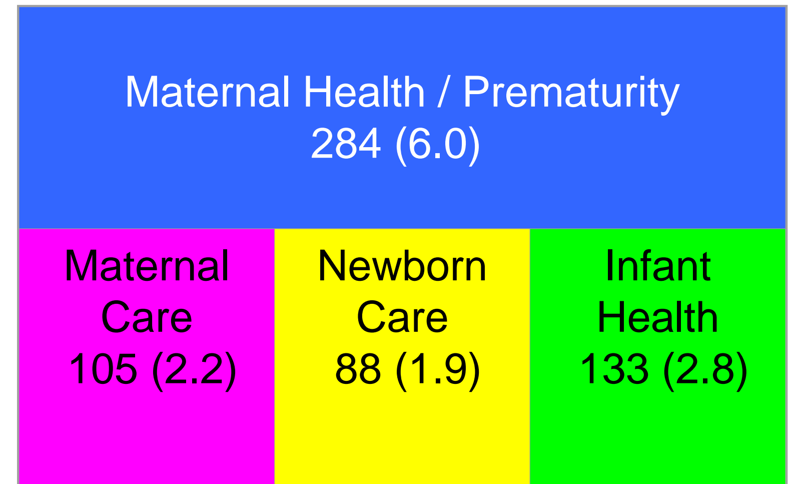


Fetal-infant deaths: 822
Fetal deaths and live births: 223,225
Overall feto-infant mortality rate: 8.6 deaths per 1,000 live births & fetal deaths

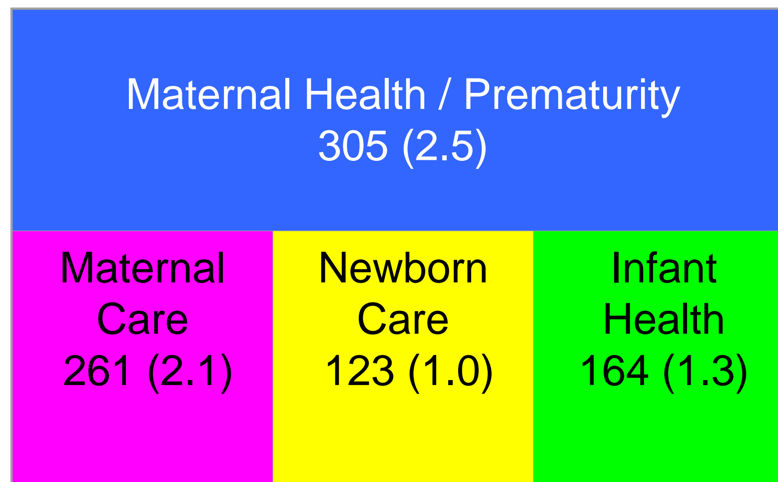
Houston Feto-Infant Mortality Rate by Race/Ethnicity, 1999-2003



White (9.1)

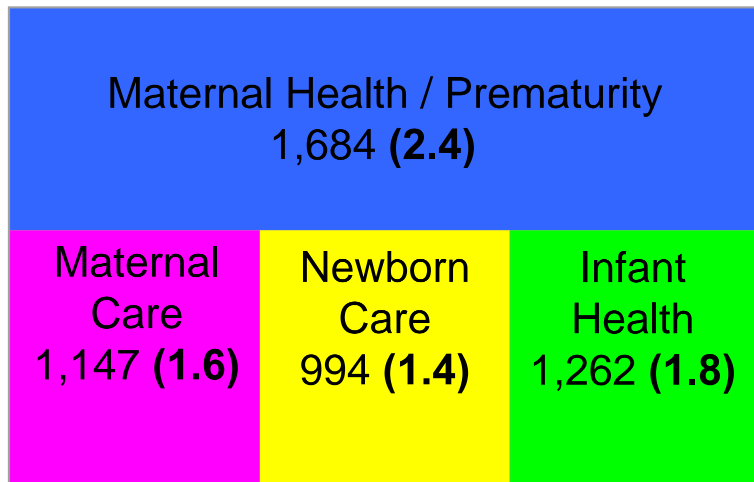


Black (12.9)

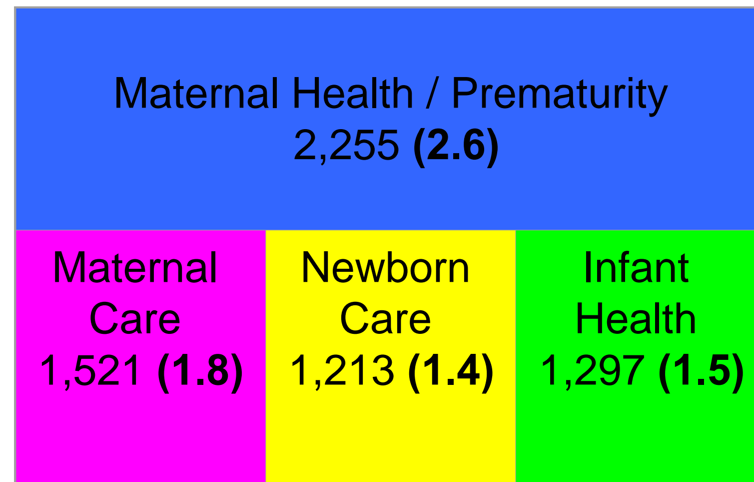


Hispanic (6.9)

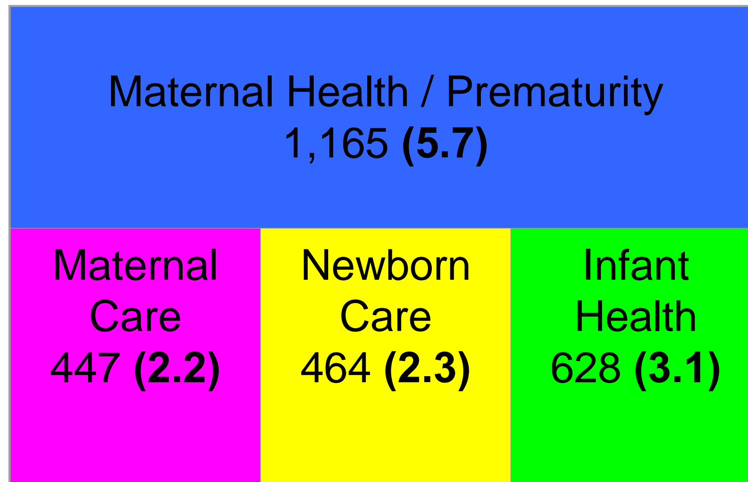
Feto-Infant Mortality Maps by Race/Ethnicity, Texas, 1999-2003



White (700,671)

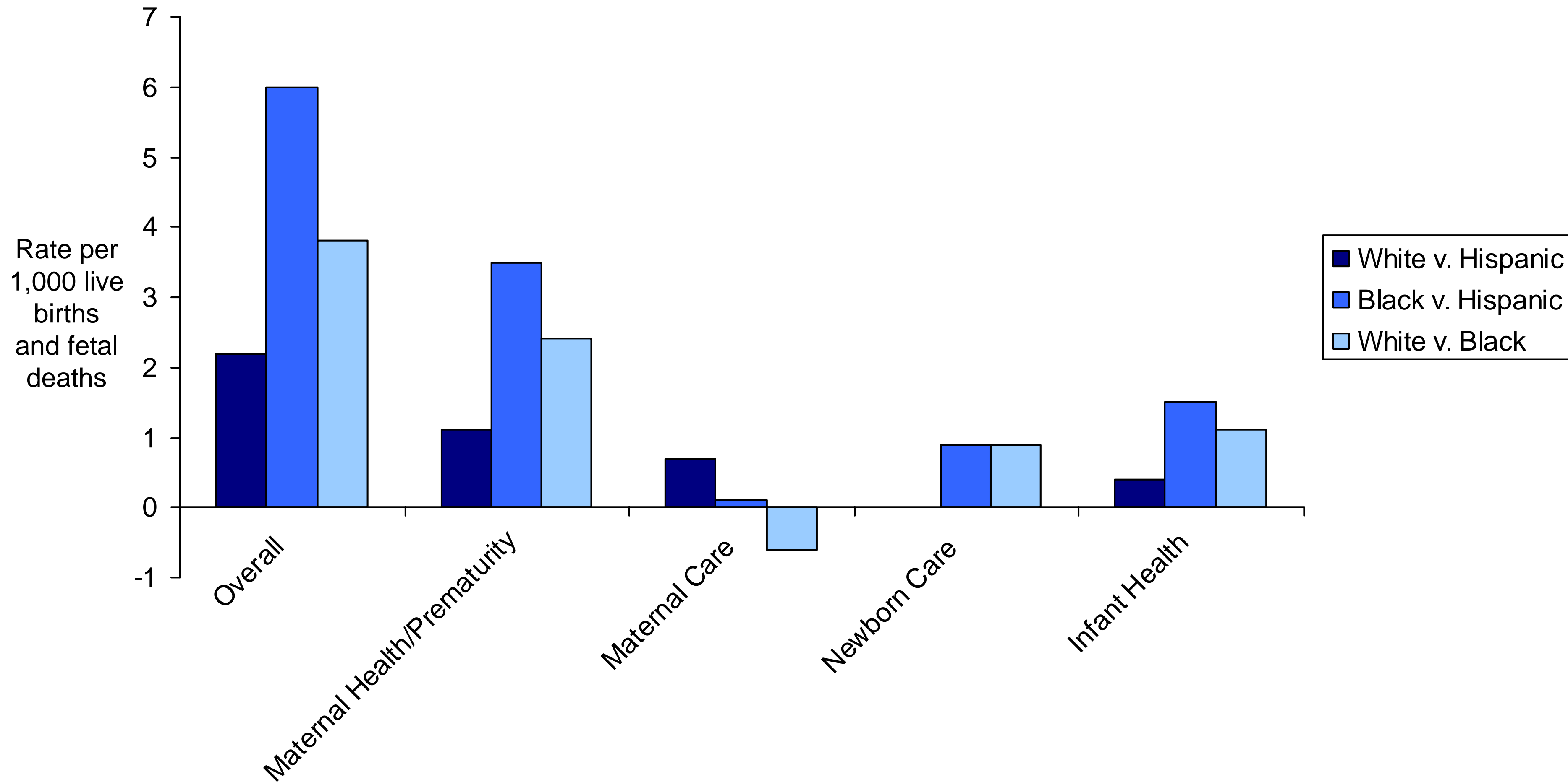


Hispanic (858,924)



African American (205,858)

Differences in Feto-Infant Mortality by Race, 1999-2003



Sunny Futures Healthy Start Target Areas (04,20,21,26,29,33,47,48,51,87) Feto-Infant Mortality Rate, 1999-2003

<table>
<tr><td colspan="3">Maternal Health / Prematurity

90 (4.1)</td></tr>
<tr><td>Maternal Care

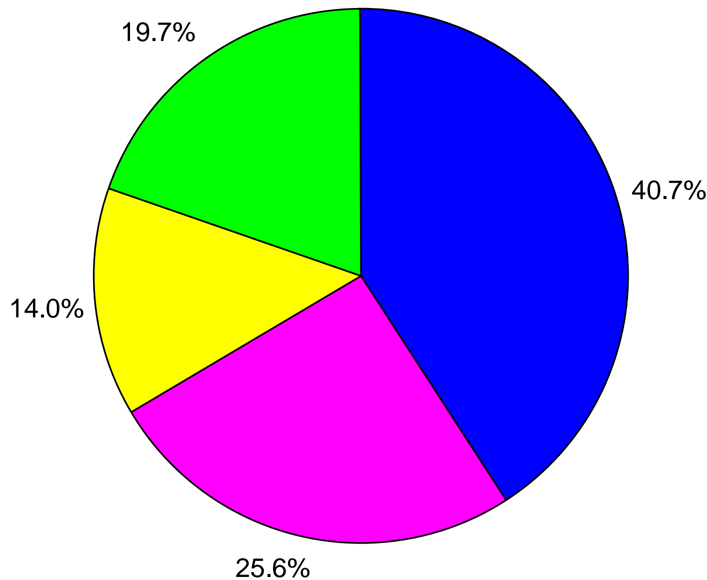
47 (2.2)</td><td>Newborn Care

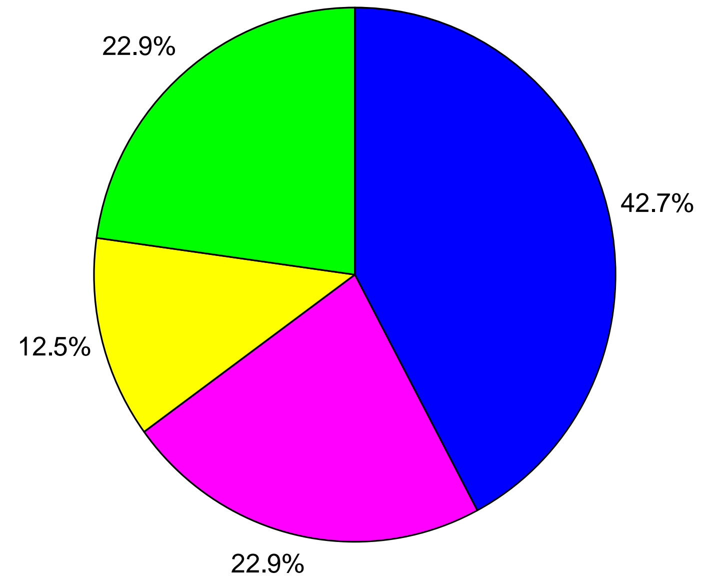
27 (1.2)</td><td>Infant Health

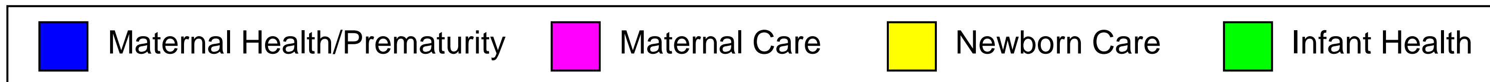
45 (2.1)</td></tr>
</table>

Fetal-infant deaths: 72
Fetal deaths and live births: 21,896
Overall feto-infant mortality rate: 9.6 deaths per 1,000 live births & fetal deaths

Comparison of the Proportion of Feto-Infant Deaths per PPOR Cell Houston and Sunny Futures Target Area

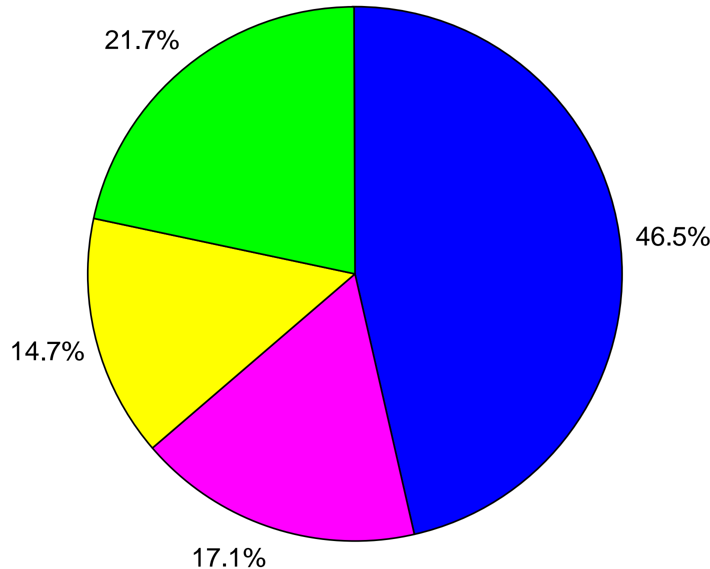


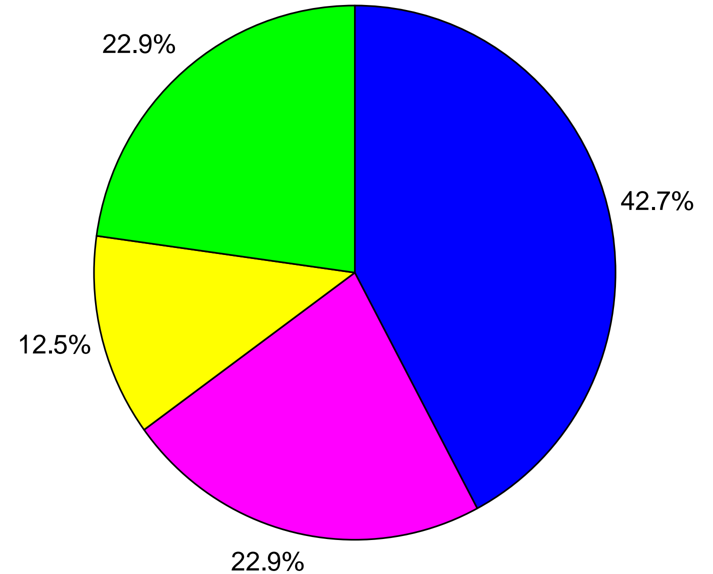


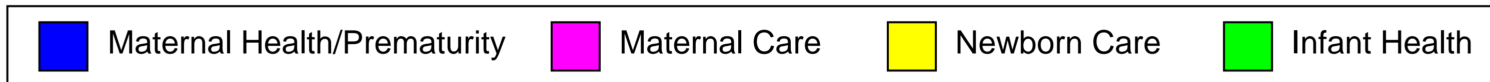


* All of Philadelphia

Comparison of the Proportion of Feto-Infant Deaths per PPOR Cell Houston and Sunny Futures Target Area







* All of Philadelphia

March of Dimes Presentation

Findings from the 2004 Texas Pregnancy Risk Assessment Monitoring System (PRAMS)

Brian C. Castrucci
Director
Family Health Research and Program Development

Data Findings Topics

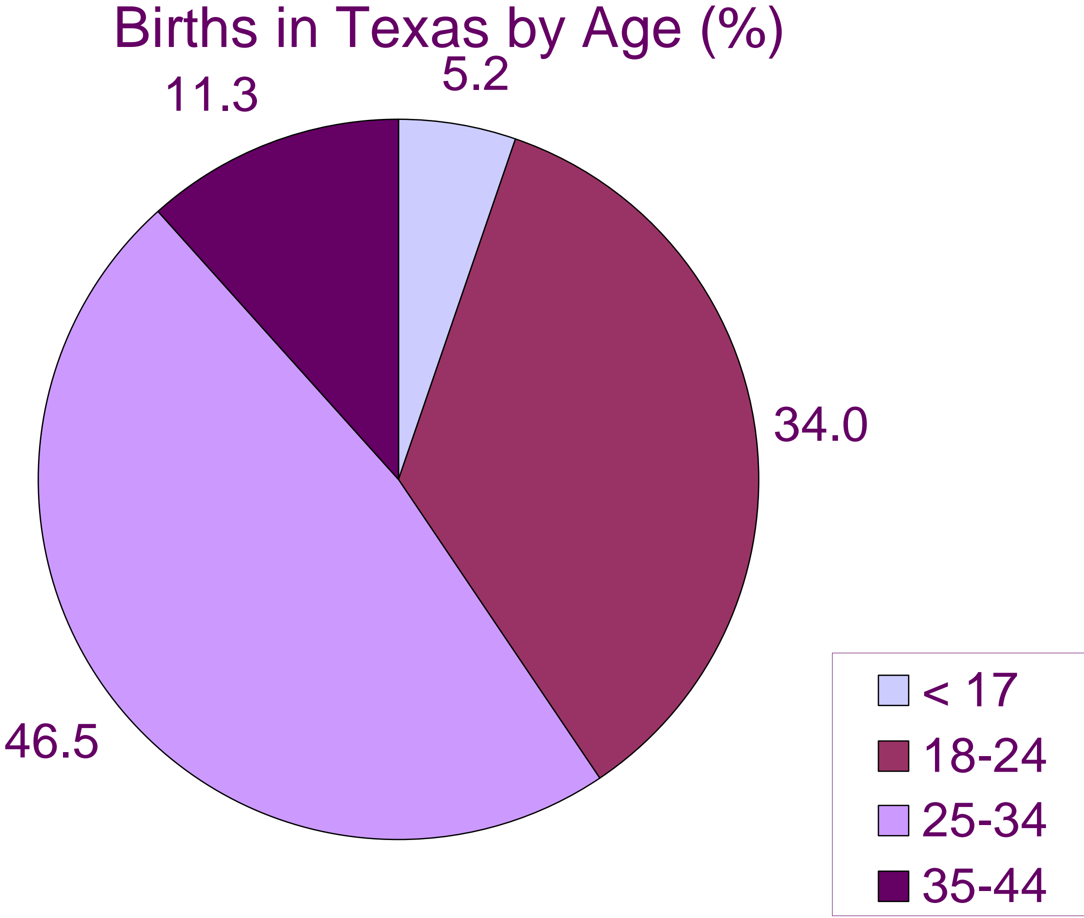
- Births in Texas
- Multivitamin Use
- Prenatal Care
- Stress and Pregnancy
- Birth Outcomes
- Pregnancy Intention

NOTE: All findings presented here use the 2004 Texas PRAMS, weighted.

Texas PRAMS

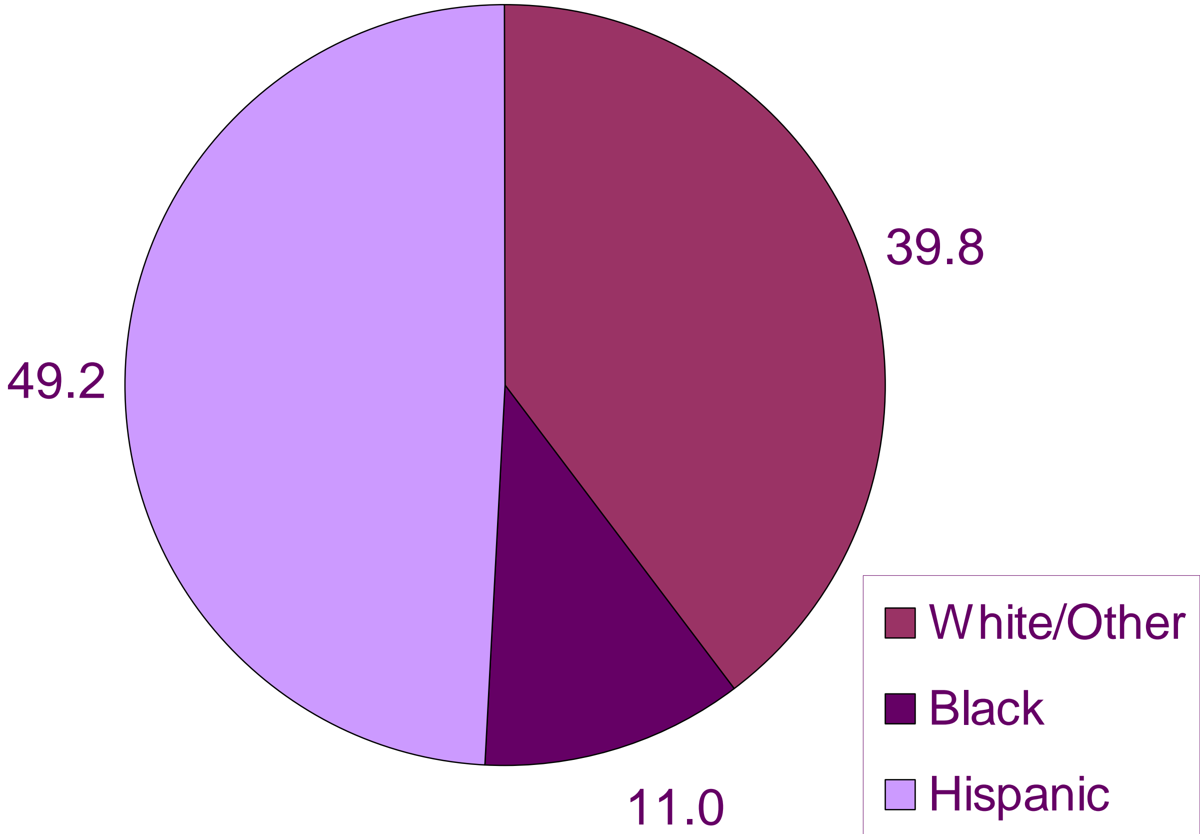
Who is giving birth?

Births in Texas



Texas PRAMS

Births in Texas



Texas PRAMS

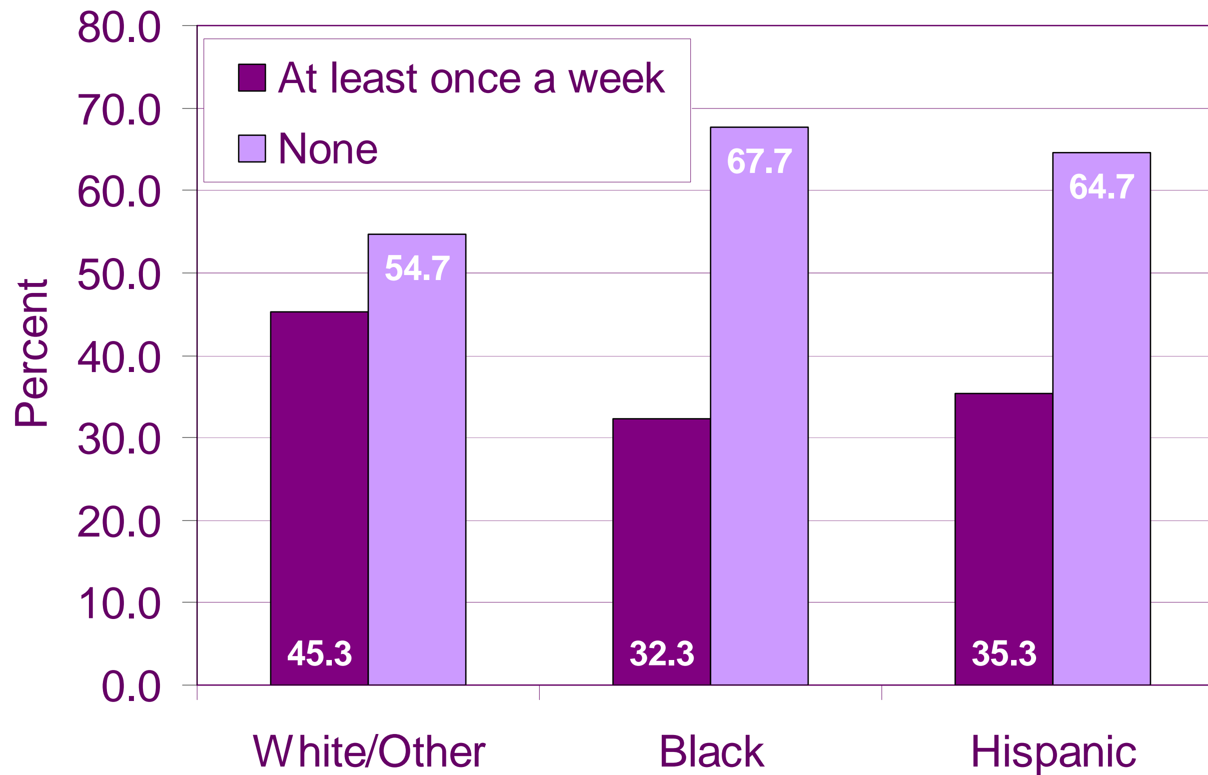
Multivitamin Use

Are women taking a multivitamin prior to pregnancy?

Texas PRAMS

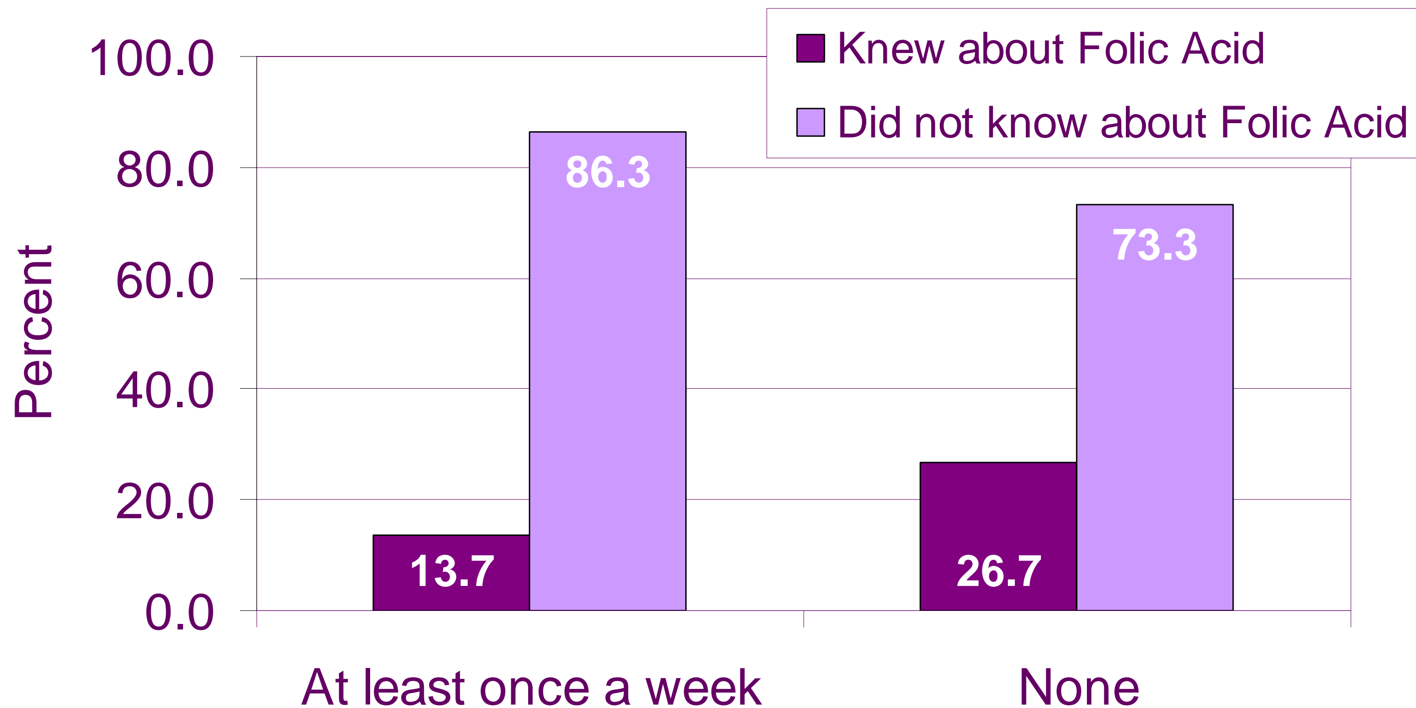
Multivitamin Use

Multivitamin Intake Prior to Pregnancy by Race-Ethnicity



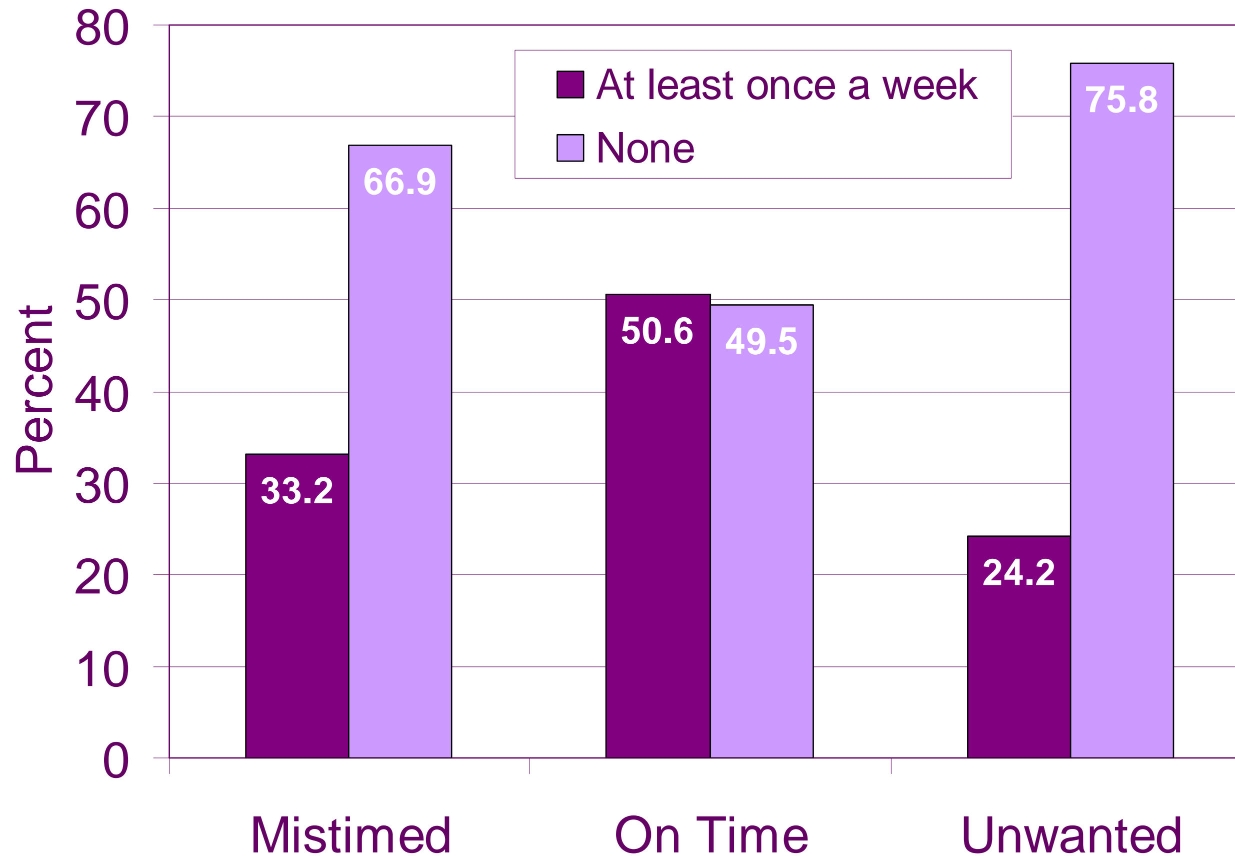
Texas PRAMS

Multivitamin Use



Texas PRAMS

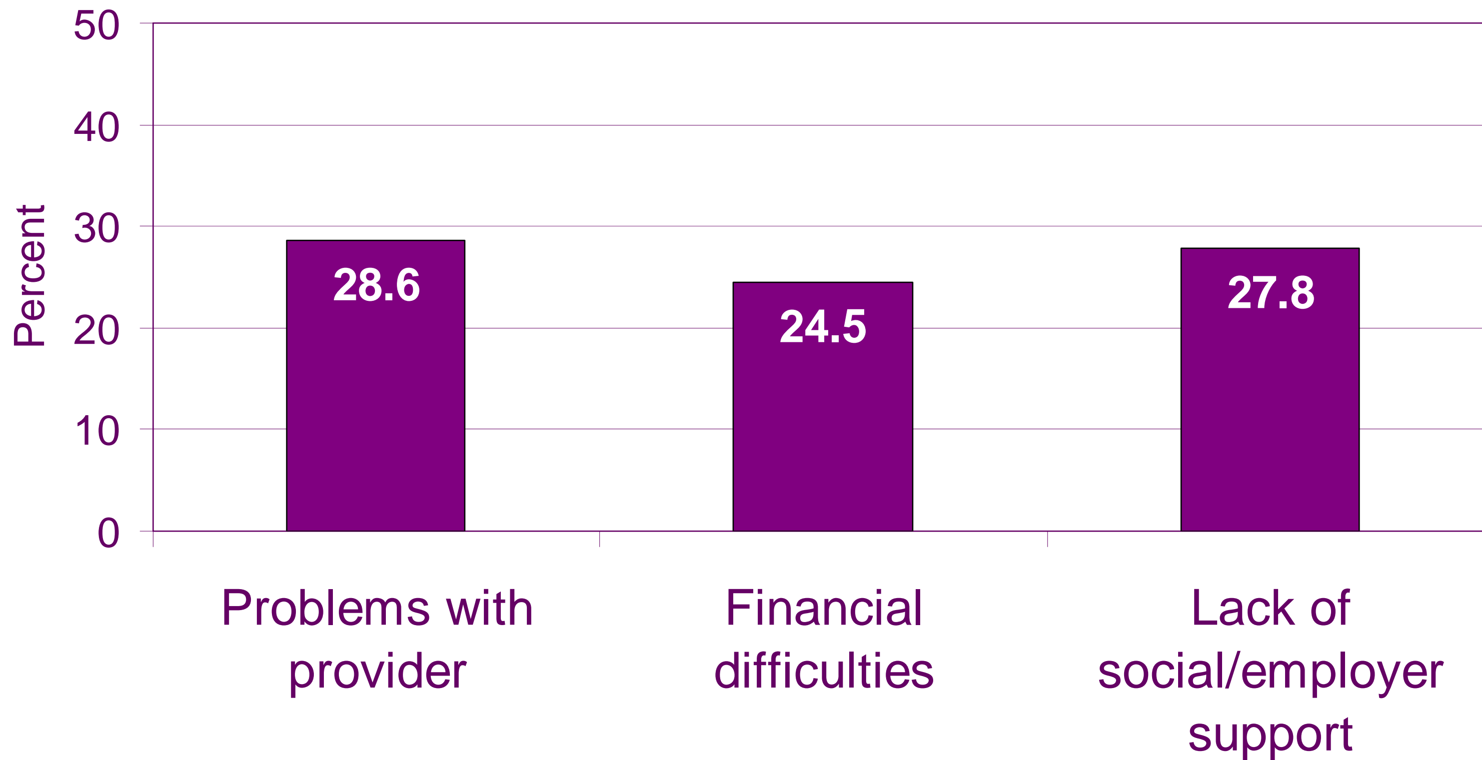
Multivitamin Use



Texas PRAMS

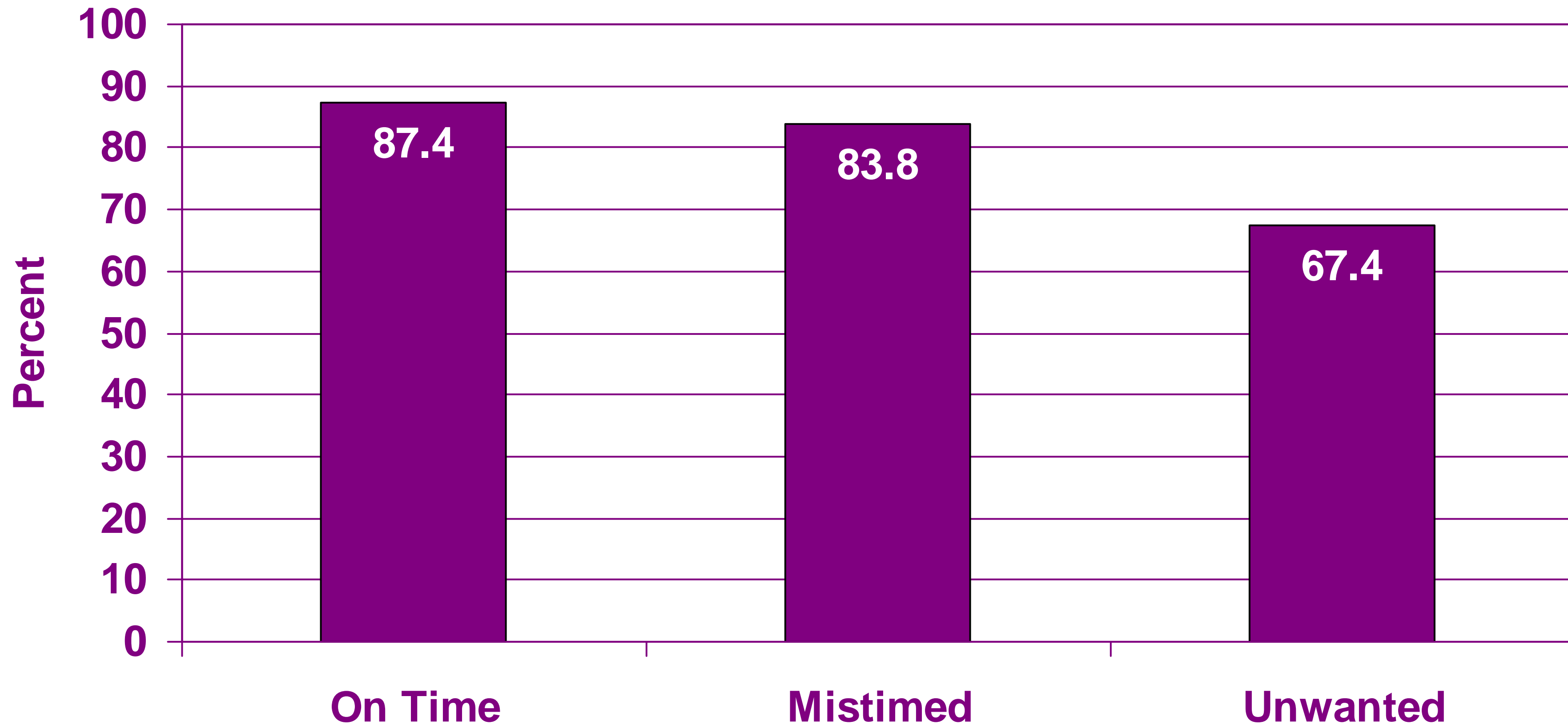
Barriers to Prenatal Care (PNC)

Prenatal Care



Texas PRAMS

Prenatal Care

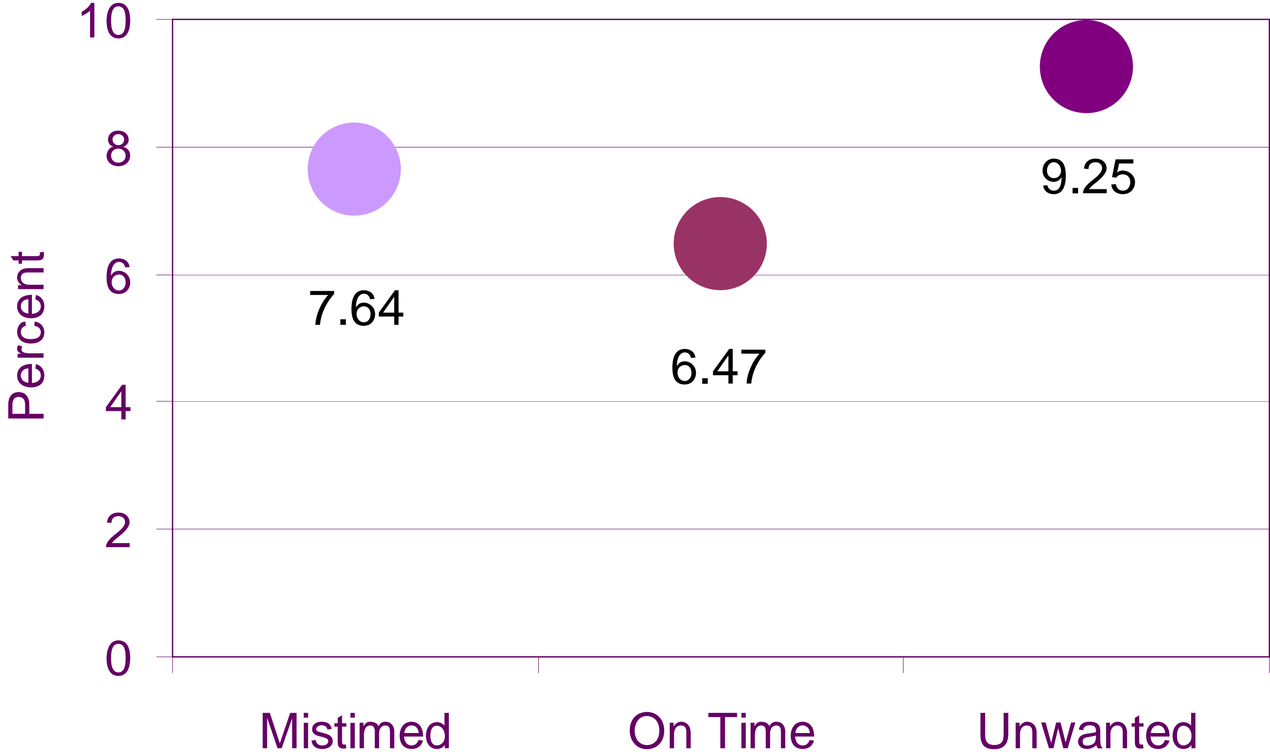


Texas PRAMS

Pregnancy Intention

Is pregnancy intention related to birth outcomes?

Pregnancy Intention



Texas PRAMS

Pregnancy Intention

Pregnancy Intention by Premature Birth

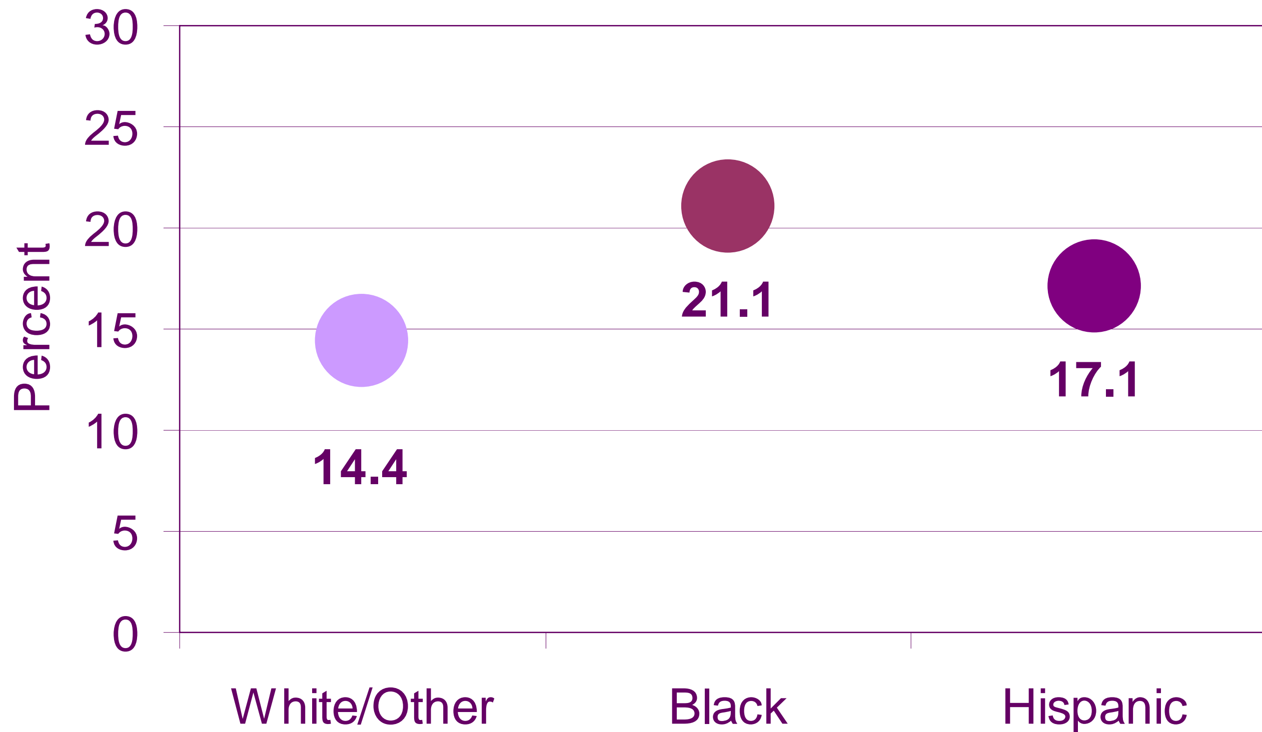
Pregnancy Intention	Percent
Mistimed	20.0
On Time	20.6
Unwanted	28.8

Attachment IV. C. NPM8

Stress and Pregnancy

Is stress during or near pregnancy related to pregnancy outcomes?

Stress and Pregnancy

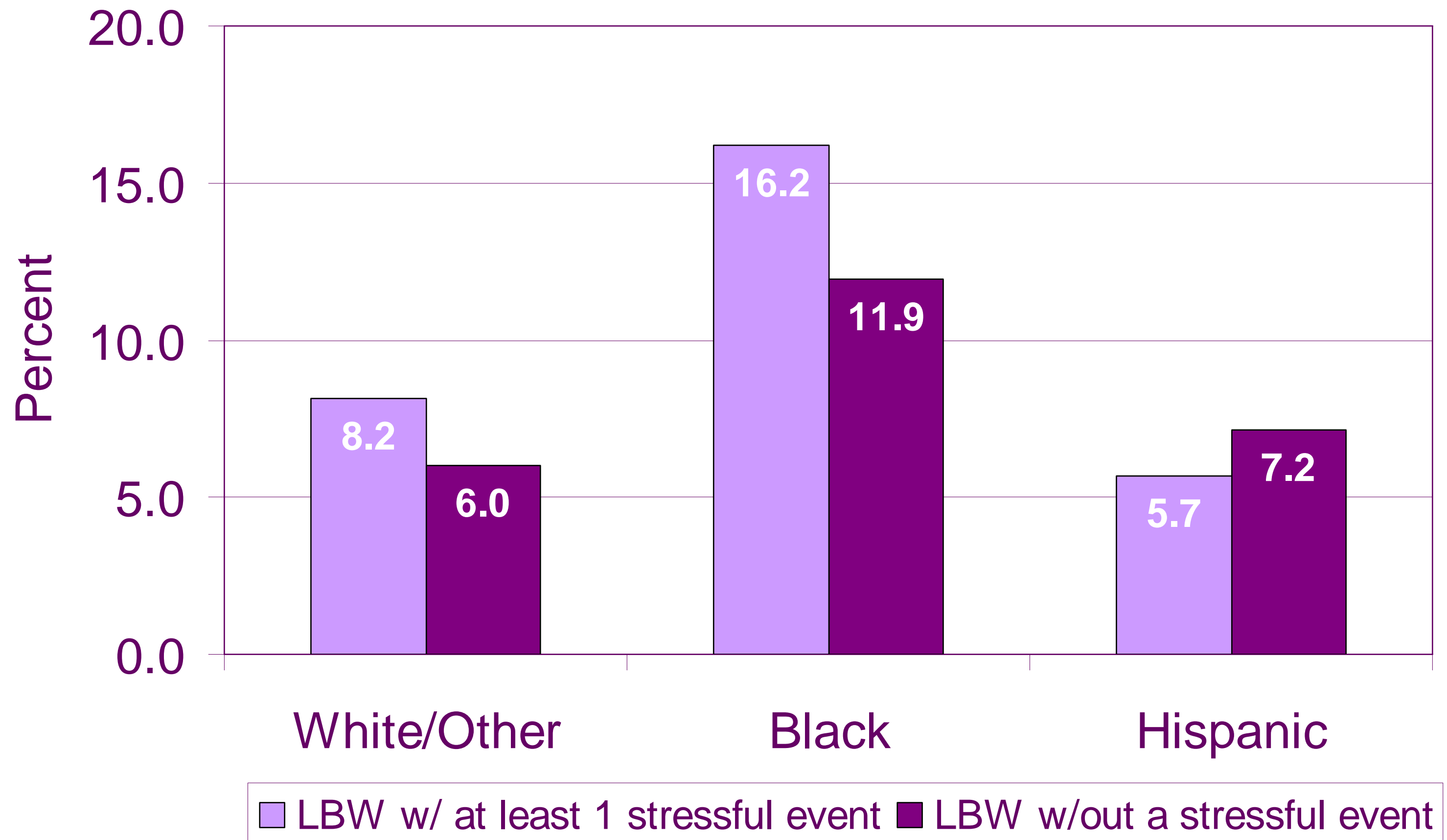


Texas PRAMS

Stress and Pregnancy

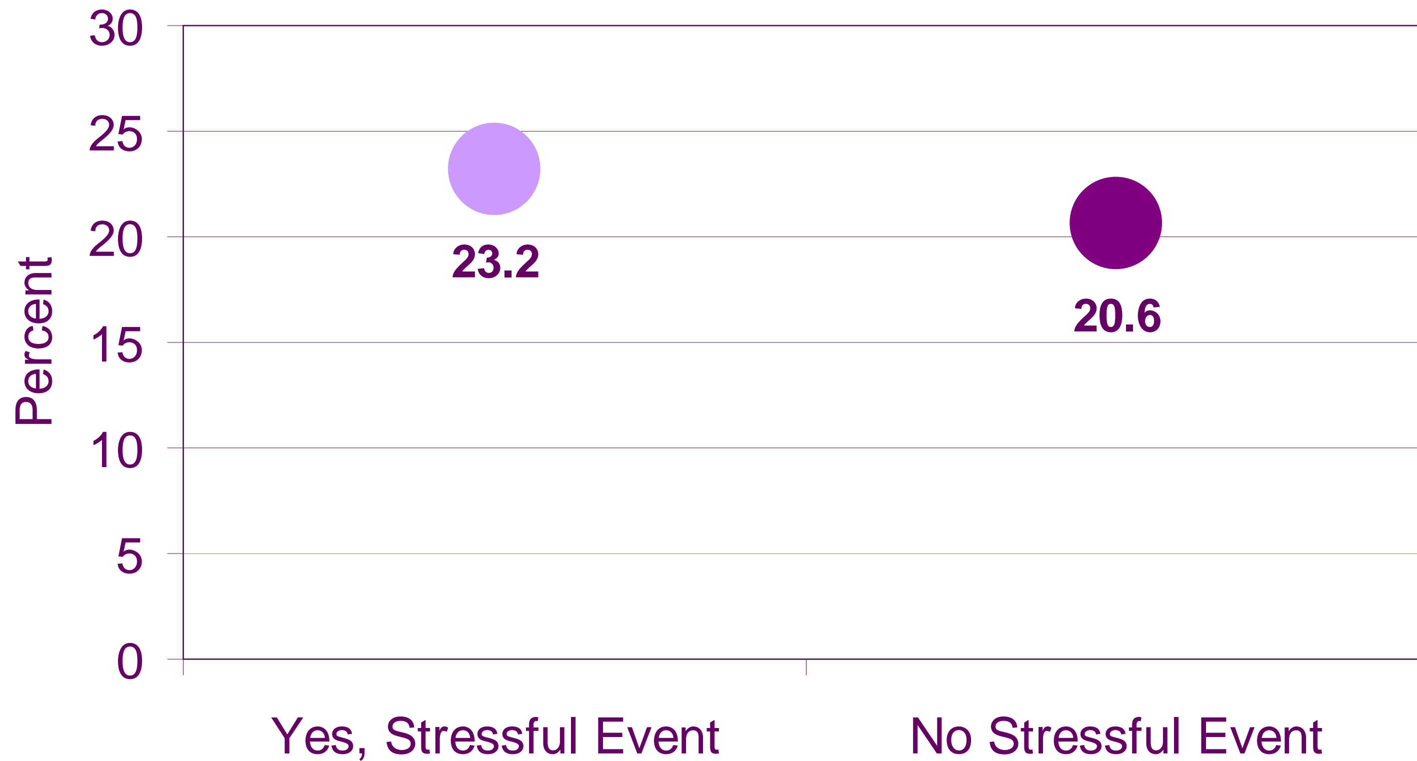
Texas PRAMS

Stress and Pregnancy



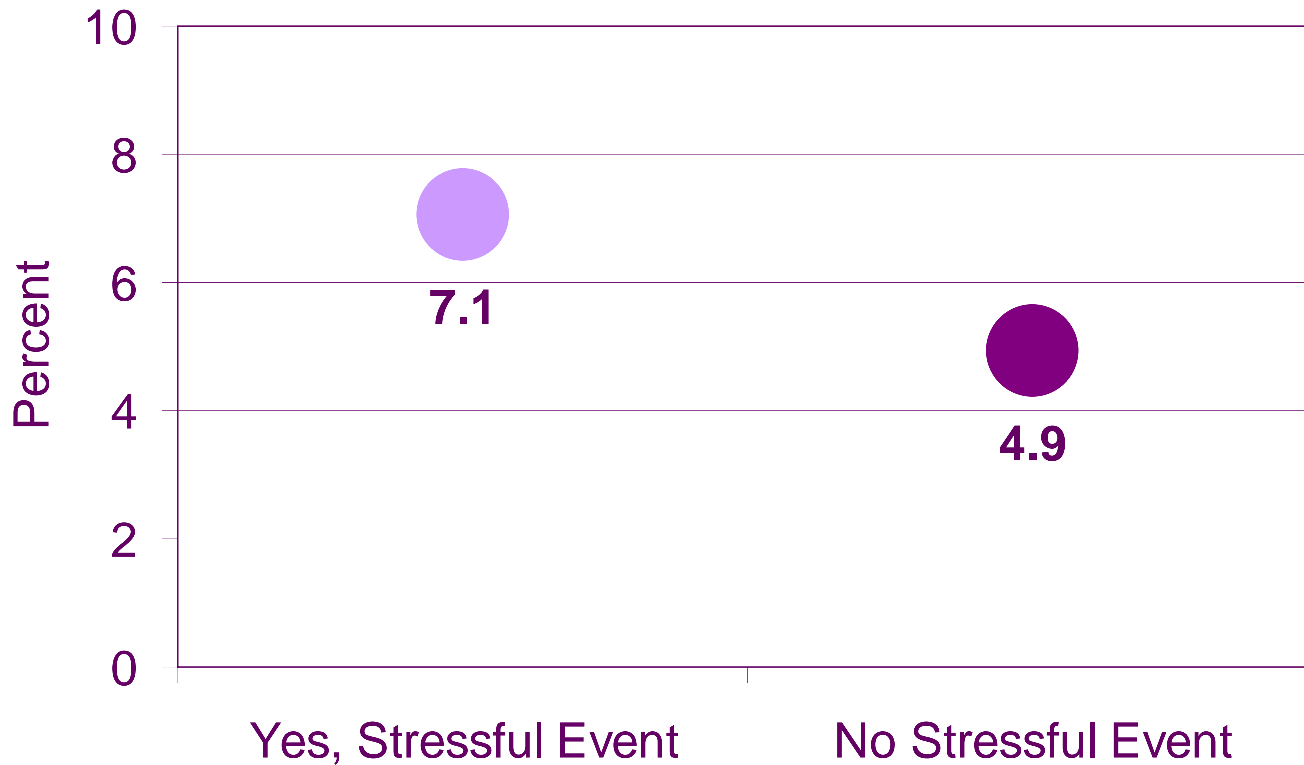
Texas PRAMS

Stress and Pregnancy



Texas PRAMS

Stress and Pregnancy



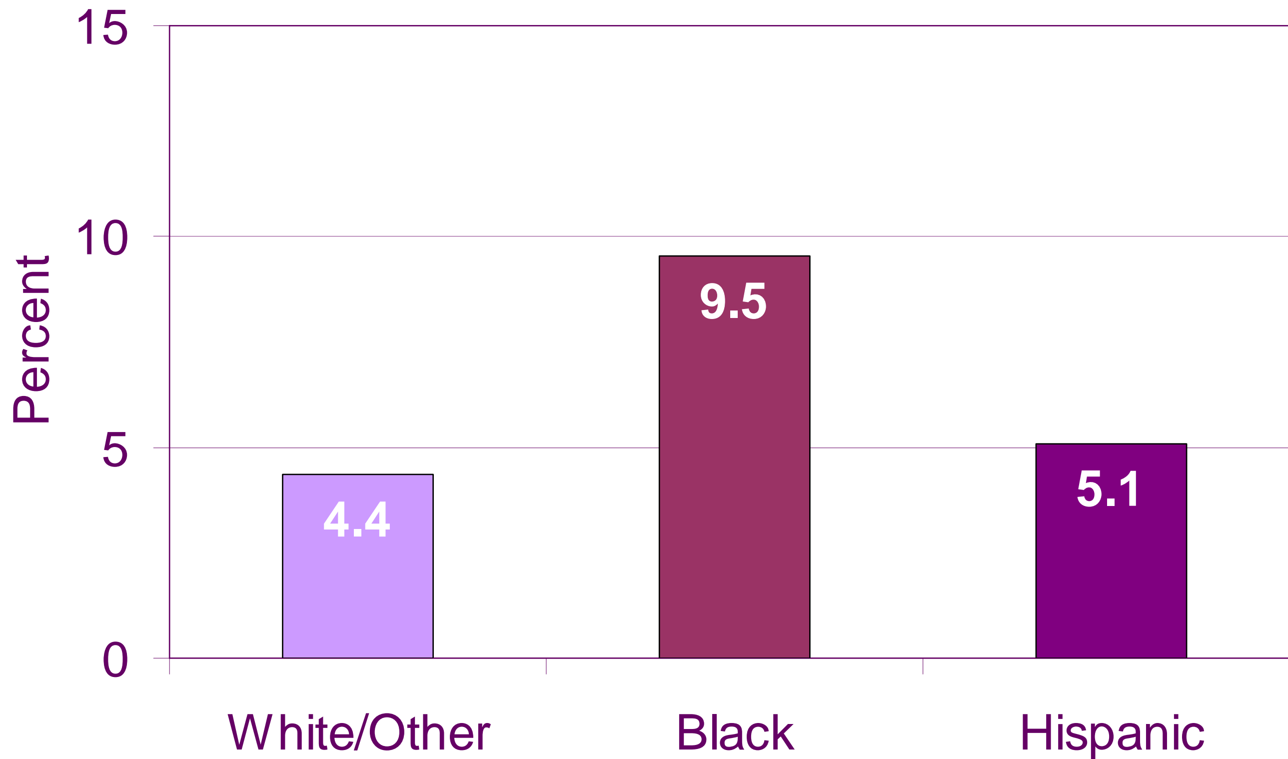
Texas PRAMS

Pregnancy Complications

Who is experiencing pregnancy complications?

Texas PRAMS

Pregnancy Complications



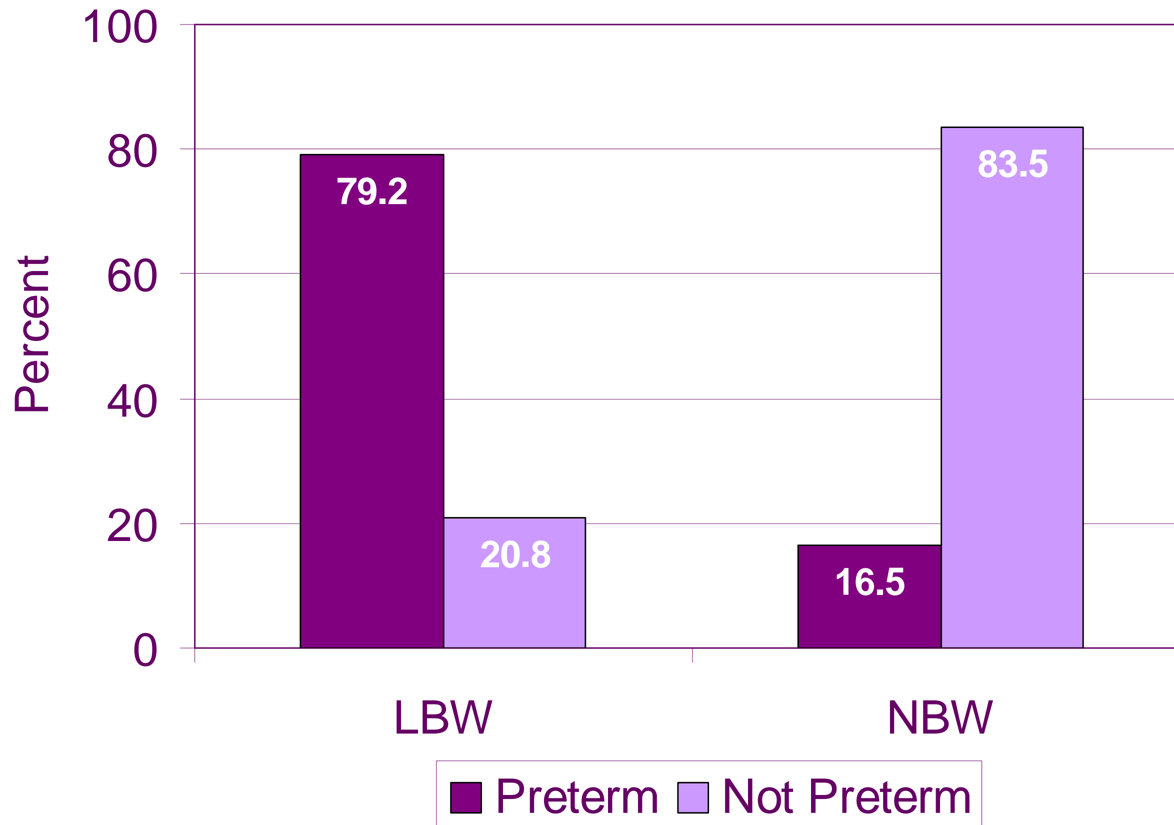
Texas PRAMS

Birth Outcomes

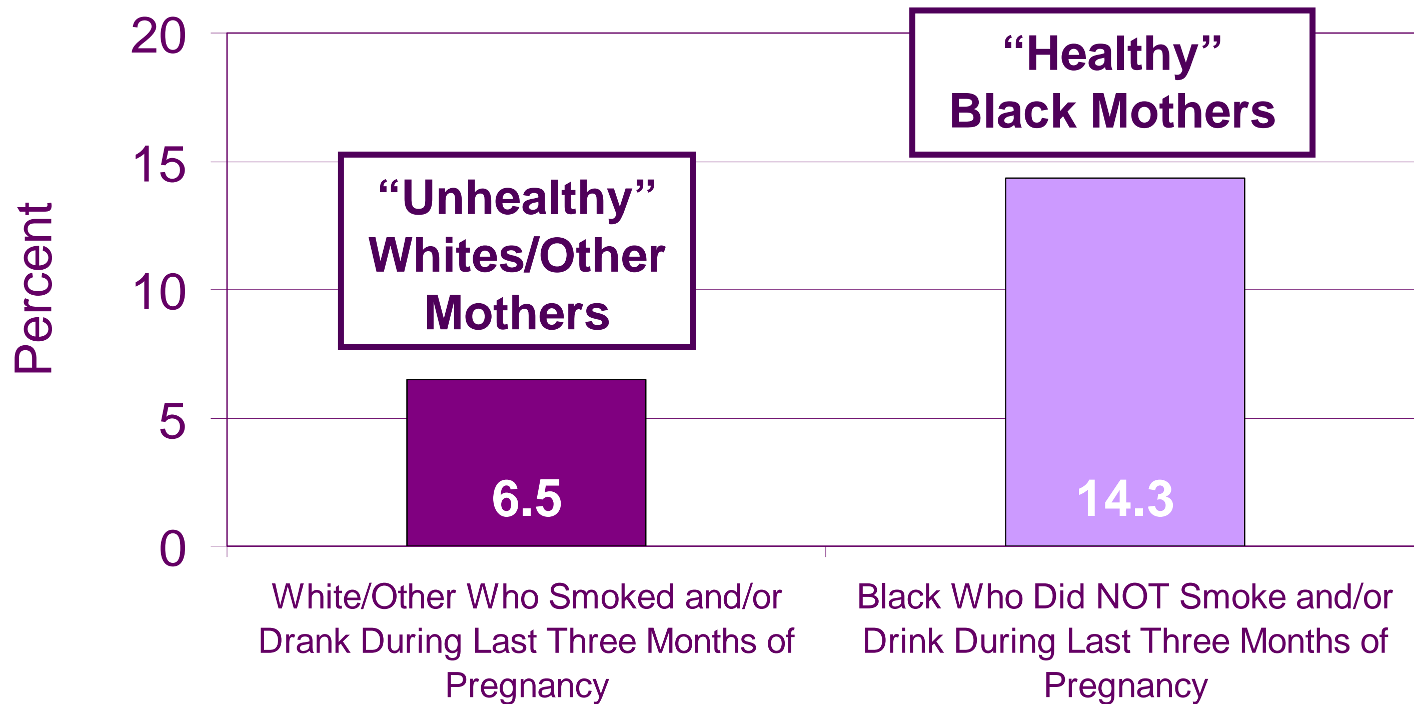
What are the birth outcomes reported in TX PRAMS?

Texas PRAMS

Birth Outcomes



Texas PRAMS



Texas PRAMS

Take Home Messages

- Increase awareness of folic acid
- Preconception health could have greatest impact on unwanted pregnancy
- Increase outreach to women who are experiencing unwanted pregnancies
- Stress impacts outcomes especially among Black women

Texas PRAMS

Take Home Messages

- Almost 20% of NBW are premature
- Significant racial disparities in LBW when comparing “unhealthy” White women to “healthy” Black women

Texas PRAMS

Trends in PRAMS Mail Response Rates in Texas

Tanya J. Guthrie, PhD; Susan Bricker, MPH; Brian C. Castrucci, MA; Fouad Berrahou, PhD

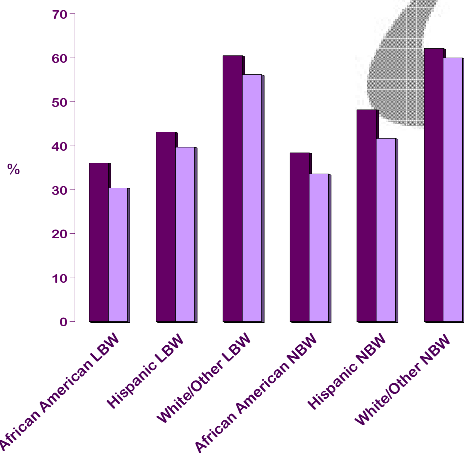
Project Background 1

- Texas PRAMS
  - Stratum specific response rates vary
    - Lower for Hispanics and African-American mothers
- Texas PRAMS State Level Goals
  - To increase response to target goal of 70%-primary focus on Hispanics and African-Americans whose response rate is lowest
  - Close the gap in response rates by obtaining more completed interviews at mail phase
- Assessment of Rewards During Mail Phase
  - Utilization of 200 minute prepaid long distance phone cards across stratum needed

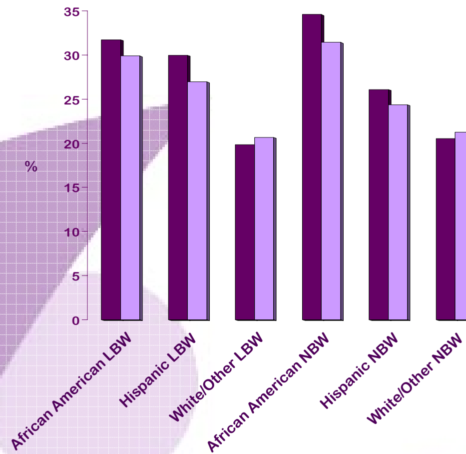
Rationale for Analysis of Rewards/Incentives 2

- Research Questions
  - What is the mail response rate (unweighgted) from 2004 to 2005?
    - Phase IV to Phase V changes in survey content and cover letter
    - Concerns over increase cell phone use with long distance calling plans
  - For those completing the survey by mail, what proportion utilized rewards (long distance phone card) at Mail 2/3?
  - What are the characteristics of those requesting rewards versus those who do not?
- Implications for Evaluating Rewards at Mail 2/3

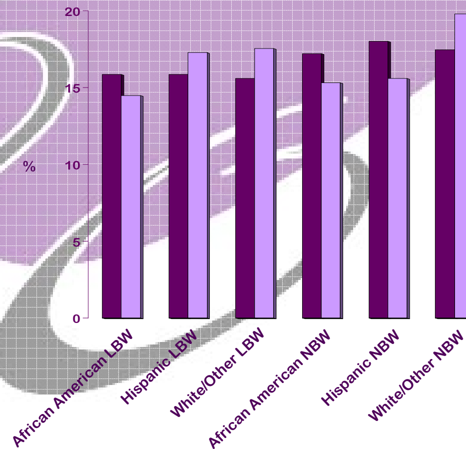
Mail Response Rate by Stratum 3



Mail Response Rate by Stratum 4

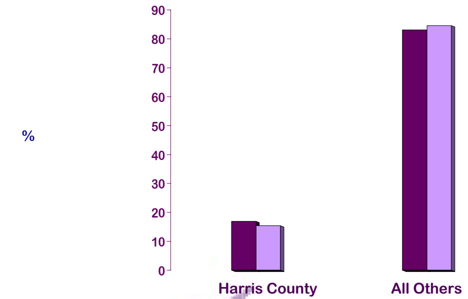


Characteristics of Requestors 5



Questions? brian.castrucci@dshs.state.tx.us

Characteristics of Requestors 6



Summary 7

- Mail response rate decline between 2004 and 2005 (Phase IV to Phase V survey and materials change)
- For those mothers who completed the survey by mail, the rate of requesting phone cards (accompanying completed survey) declined from 2004 to 2005
  - Largest declines seen in African American (LBW & NBW) and Hispanic (NBW) in the pool of those requesting phone cards declined from 2004 to 2005
  - Largest declines seen in African American and Hispanic strata. White/Other showed little change.
- Characteristics of requestors
  - The proportion of African American (LBW & NBW) and Hispanic (NBW) in the pool of those requesting phone cards declined from 2004 to 2005
  - The proportion of requestors from Harris County declined slightly from 2004 to 2005

Next Steps 8

- Conduct focus groups
  - City of Houston/Harris County area participants
    - Houston has highest representation in batch (averages 15% of the sample)
  - Propose different types of incentives to focus group participants
    - Which ones work? Which ones should not be considered?
  - Agency review of report on focus groups
- Change incentives or rewards
  - Document implementation of new incentives/rewards
- Evaluate
  - Examine trends in response rates by specific stratum to evaluate impact of change

THE CASE STUDY OF A BREASTFEEDING OUTREACH CAMPAIGN ON RURAL YOUNG ADULT/ ADOLESCENT AFRICAN AMERICAN WOMEN

[1]M. Aaron Sayegh, [2]Tracy Erickson , R.D., L.D., [3]J. Dennis Fortenberry, M.D., M.S., and [1]Brian Castrucci, M.A.

[1]Family Health Research and Program Development Unit and [2]Nutrition Services Section, Texas Dept of State Health Services, Austin, TX. [3]Dept of Pediatrics, Indiana Univ. School of Med, Indianapolis, IN.

Introduction

- Breastfeeding is an important public health goal
- Breastfeeding rates among African American women lag behind all other ethnic groups
- Breastfeeding is a much less common infant feeding choice among young, rural, African American women
- Texas Women, Infants and Children (WIC) piloted a targeted media breastfeeding outreach campaign to young African American women to increase rates among its clientele
- Breastfeeding rates increased among participants
- Increasing the rates of breastfeeding could narrow many of the health disparities that are prevalent among African Americans such as:
  - ❖ SIDS, diabetes, overweight, obesity and asthma

Objective

- This case study examines the campaign elements that were effective

Methods

Data

- Interviews with 32 women:
  - ❖African-American women
  - ❖Expectant or new mothers
  - ❖Ages 17- 25
  - ❖Receiving WIC
  - ❖Population of 600 women
  - ❖1 of 3 rural regions of Texas
  - ❖Pre- (Dec. 2003) and post- (Oct. 2004) campaign
- Interviews with 15 healthcare providers at participating facilities were also interviewed pre- and post-campaign

Instrument

- Participant interviews focus:
  - ❖Knowledge of breastfeeding
  - ❖Availability of materials and information
  - ❖Discussions at home or in the community
- Provider interviews focus:
  - ❖Perceived barriers
  - ❖Availability of materials and information
  - ❖Attitudes and experiences with WIC

Analysis

- Thematic analyses identified the content of interview focal categories.
- Patterns in the themes were then traced in the data.

Methods (continued)

Media Campaign

- Involved posters, pamphlets and billboards, radio, television, newspaper and magazine ads, community presentations and distribution of breastfeeding education bags
- Media ads rolled out with increased frequency and visibility over the 9 months
- Presentations at local faith organizations were intended to reach the mothers and grandmothers of African American women

Results

Pre Campaign

- At pre-campaign, young mothers identified "fear of breastfeeding" and "fear of the pain of breastfeeding" as barriers
- Providers identified "a lack of interest" and "fear of pain" as reasons why young mothers do not to breastfeed
- Younger mothers reported that information was not offered at providers' offices
- Both younger mothers and providers reported a lack of public discussion
- Young mothers identified their own mothers and grandmothers as important influences

Campaign Materials

Results (continued)

Post Campaign

- Providers reported that African American mothers asked them more breastfeeding questions
- Young mothers' breastfeeding attitudes included "socially responsible" and "less socially restrictive"
- Intention to breastfeed increased

Contact : aaron.sayegh@dshs.state.tx.us

Discussion

- Adolescent and young adult mothers are responsive to efforts to increase breastfeeding
- The mothers and grandmothers of expectant or new mothers could be an important health promotional target for breastfeeding campaigns
- Close attention to strategic radio placement
  - ❖ local hip-hop stations that appeal to young African Americans
  - ❖ local gospel stations that appeal to their mothers and grandmothers

Conclusions

- Healthcare providers should not assume that young, poor, African American women are uninterested in breastfeeding
- Provision of informational materials to expectant mothers at health care facilities is important
- Encouragement and support by referrals to classes and other resources are important elements of successful programs

Attachment IV. C. NPM11

Title V Block Grant Application
Forms (2-21)
State: TX
Application Year: 2008

- Form 2 - MCH Budget Details
- Form 3 - State MCH Funding Profile
- Form 4 - Budget Details By Types of Individuals Served and Sources of Federal Funds
- Form 5 - State Title V Program Budget and Expenditures by Types of Services
- Form 6 - Number and Percentage of Newborn and Others Screened, Case Confirmed, and Treated
- Form 7 - Number of Individuals Served (Unduplicated) Under Title V
- Form 8 - Deliveries and Infants Served by Title V and Entitled to Benefits under Title XIX
- Form 9 - State MCH Toll-Free Telephone Line Data
- Form 10 - Title V Maternal and Child Health Services Block Grant State Profile for FY 2004
- Form 11 - National and State Performance Measures
- Form 12 - National and State Outcome Measures
- Form 13 - Characteristics Documenting Family Participation in Children with Special Health Care Needs
- Form 14 - List of MCH Priority Needs
- Form 15 - Technical Assistance (TA) Request and tracking
- Form 16 - State Performance/Outcome Measure Detail Sheets
- Form 17 - Health System Capacity Indicators (01 through 04,07,08) - Multi-Year Data
- Form 18
  - Medicaid and Non-Medicaid comparison
  - Medicaid Eligibility Level (HSCI 06)
  - SCHIP Eligibility Level (HSCI 06)
- Form 19
  - General MCH Data Capacity (HSCI 09A)
  - Adolescent Tobacco Use Data Capacity (HSCI 09B)
- Form 20 - Health Status Indicators 01-05 - Multi-Year Data
- Form 21
  - Population Demographics Data (HSI 06)
  - Live Birth Demographics Data (HSI 07)
  - Infant and Children Mortality Data (HSI 08)
  - Miscellaneous Demographics Data (HSI 09)
  - Geographic Living Area Demographic Data (HSI 10)
  - Poverty Level Demographic Data (HSI 11)
  - Poverty Level for Children Demographics Data (HSI 12)

FORM 2

MCH BUDGET DETAILS FOR FY 2008

[Secs. 504 (d) and 505(a)(3)(4)]

STATE: TX

1. FEDERAL ALLOCATION $ 35,207,084
(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:

A.Preventive and primary care for children:

$ 10,562,125 (30%)

B.Children with special health care needs:

$ 10,562,125 (30%)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V admininstrative costs:

$ 3,520,708 (10%)

(The above figure cannot be more than 10%)[Sec. 504(d)]

2. UNOBLIGATED BALANCE (Item 15b of SF 424) $ 5,170,187

3. STATE MCH FUNDS (Item 15c of the SF 424) $ 46,447,844

4. LOCAL MCH FUNDS (Item 15d of SF 424) $ 0

5. OTHER FUNDS (Item 15e of SF 424) $ 250,000

6. PROGRAM INCOME (Item 15f of SF 424) $ 2,527,780

7. TOTAL STATE MATCH (Lines 3 through 6) $ 49,225,624
(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 40,208,728

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 89,602,895
(Total lines 1 through 6. Same as line 15g of SF 424)

9. OTHER FEDERAL FUNDS
(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 0
b. SSDI:	$ 94,570
c. CISS:	$ 0
d. Abstinence Education:	$ 0
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 512,913,733
h. AIDS:	$ 0
i. CDC:	$ 7,190,329
j. Education:	$ 0
k. Other:	
Family Planning(T-X)	$ 12,024,000
NHSCPC/MaleInvolveme	$ 321,670

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9) $ 532,544,302

11. STATE MCH BUDGET TOTAL $ 622,147,197
(Partnership subtotal + Other Federal MCH Funds subtotal)

FORM NOTES FOR FORM 2

None

FIELD LEVEL NOTES

None

FORM 3

[Secs. 505(a) and 506(a)(1-3)]

	FY2003		FY2004		FY2005		FY2006		FY2007		FY2008	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. **Federal Allocation** (Line 1, Form 2)	$ 38,661,981	$ 29,802,848	$ 37,908,796	$ 23,640,071	$ 37,574,044	$ 23,746,828	$ 35,197,324	$ 27,047,556	$ 35,207,084	$ 30,036,897	$ 35,207,084	$
2. **Unobligated Balance** (Line 2, Form 2)	$ 1,759,559	$ 1,759,559	$ 8,859,133	$ 8,859,133	$ 14,268,725	$ 14,268,725	$ 13,827,216	$ 13,827,216	$ 8,149,768	$ 8,149,768	$ 5,170,187	$
3. **State Funds** (Line 3, Form 2)	$ 51,300,000	$ 48,100,000	$ 52,334,404	$ 44,580,507	$ 45,910,863	$ 43,379,784	$ 49,894,116	$ 46,068,918	$ 49,894,116	$ 46,995,124	$ 46,447,844	$
4. **Local Funding** (Line 4, Form 2)	$	$	$	$	$	$	$	$	$	$	$	$
5. **Other** (Line 5, Form 2)	$ 300,000	$ 300,000	$ 246,930	$ 245,497	$ 279,634	$ 207,142	$ 287,452	$ 287,452	$ 286,529	$ 286,529	$ 250,000	$
6. **Program Income** (Line 6, Form 2)	$ 2,400,000	$ 2,400,000	$ 3,409,139	$ 2,870,794	$ 3,490,550	$ 2,196,132	$ 3,722,135	$ 1,773,601	$ 3,722,135	$ 2,854,635	$ 2,527,780	$
7. **SUB-TOTALS** (Line 7, Form 2)	$ 94,421,540	$ 82,362,407	$ 102,758,402	$ 80,196,002	$ 101,523,816	$ 83,798,612	$ 102,928,243	$ 89,004,743	$ 97,259,632	$ 88,322,953	$ 89,602,895	$ 0
8. **Other Federal Funds** (Line 9, Form 2)	$ 484,429,424	$ 449,746,927	$ 521,110,673	$ 487,525,745	$ 528,211,678	$ 507,420,598	$ 527,115,105	$ 499,536,838	$ 537,081,223	$ 496,670,448	$ 532,544,302	$ 0
9. **TOTAL** (Line 10, Form 2)	$ 578,850,964	$ 532,109,334	$ 623,869,075	$ 567,721,747	$ 629,735,494	$ 591,219,209	$ 630,043,348	$ 588,541,581	$ 634,340,855	$ 584,993,401	$ 622,147,197	$ 0

FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I); AND
SOURCES OF OTHER FEDERAL FUNDS(II)
[Sec. 506(a)(2)(iv)]

		FY 2003		FY 2004	
I.	**Federal-State MCH Block Grant Partnership**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a.	Pregnant Women	$ 19,350,691	$ 16,879,300	$ 22,152,456	$ 17,288,498
b.	Infants < 1 year old	$ 201,057	$ 175,379	$ 216,503	$ 168,966
c.	Children 1 to 22 years old	$ 23,198,853	$ 20,235,990	$ 22,132,503	$ 17,272,926
d.	CSHCN	$ 29,744,547	$ 25,945,695	$ 34,882,581	$ 27,223,502
e.	All Others	$ 11,448,426	$ 9,986,280	$ 10,551,368	$ 8,234,631
f.	Administration	$ 10,477,967	$ 9,139,764	$ 12,822,990	$ 10,007,479
g.	**SUB-TOTAL**	$ 94,421,540	$ 82,362,408	$ 102,758,402	$ 80,196,002
		(Line 7, Form 2 & 3)	(Line 7, Form 3)	(Line 7, Form 2 & 3)	(Line 7, Form 3)
		94,421,540.00	82,362,407.00	102,758,402.00	80,196,002.00
		ck figure	ck figure	ck figure	ck figure
II.					
a.	SPRANS	$ 112,600	$ 37,566	$ 212,311	$ 142,397
b.	SSDI	$ 99,999	$ 29,899	$ 90,000	$ 55,492
c.	CISS	$ 0	$ 0	$ 0	$ 0
d.	Abstinence Education	$ 4,922,091	$ 4,841,275	$ 4,880,089	$ 4,764,645
e.	Healthy Start	$ 0	$ 0	$ 0	$ 0
f.	EMSC	$ 0	$ 0	$ 0	$ 0
g.	WIC	$ 455,505,439	$ 422,280,111	$ 491,580,339	$ 460,227,931
h.	AIDS	$ 0	$ 0	$ 0	$ 0
i.	CDC	$ 7,484,194	$ 6,788,268	$ 7,824,158	$ 7,380,395
j.	Education	$ 0	$ 0	$ 0	$ 0
k.	Other: Family Planning (T-X)	$ 15,623,935	$ 15,163,079	$ 16,080,182	$ 14,570,865
	Other: Respite/NHSCPC/Fragile	$ 681,166	$ 606,729	$ 443,594	$ 384,020
III.	**SUB-TOTAL**	$ 484,429,424	$ 449,746,927	$ 521,110,673	$ 487,525,745
		(Line 9, Form 2) and Line 8, Form 3)		(Line 9, Form 2) and Line 8, Form 3)	

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FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I); AND
SOURCES OF OTHER FEDERAL FUNDS(II)
[Sec. 506(a)(2)(iv)]

		FY 2005 Budgeted	FY 2005 Expended	FY 2006 Budgeted	FY 2006 Expended
I.	**Federal-State MCH Block Grant Partnership**				
a.	Pregnant Women	$ 19,094,849	$ 15,761,049	$ 19,997,904	$ 17,292,711
b.	Infants < 1 year old	$ 186,620	$ 154,037	$ 195,446	$ 169,007
c.	Children 1 to 22 years old	$ 24,858,715	$ 20,518,593	$ 25,131,261	$ 21,731,658
d.	CSHCN	$ 35,910,448	$ 29,640,786	$ 39,324,632	$ 34,005,037
e.	All Others	$ 9,095,009	$ 7,507,097	$ 9,525,140	$ 8,236,638
f.	Administration	$ 12,378,174	$ 10,217,049	$ 8,753,860	$ 7,569,692
g.	**SUB-TOTAL**	$ 101,523,816	$ 83,798,612	$ 102,928,243	$ 89,004,743
		(Line 7, Form 2 & 3)	(Line 7, Form 3)	(Line 7, Form 2 & 3)	(Line 7, Form 3)
		101,523,816.00	83,798,611.52	102,928,243.00	89,004,743.00
		ck figure	ck figure	ck figure	ck figure
II.					
a.	SPRANS	$ 101,139	$ 72,177	$ 50,000	$ 12,519
b.	SSDI	$ 90,000	$ 71,818	$ 115,000	$ 84,030
c.	CISS	$ 0	$ 0	$ 0	$ 0
d.	Abstinence Education	$ Moved out of Assoc	$ 0	$ 0	$ 0
e.	Healthy Start	$ 0	$ 0	$ 0	$ 0
f.	EMSC	$ 0	$ 0	$ 0	$ 0
g.	WIC	$ 502,070,466	$ 483,240,731	$ 502,162,801	$ 475,847,418
h.	AIDS	$ 0	$ 0	$ 0	$ 0
i.	CDC	$ 8,338,851	$ 7,667,287	$ 8,371,203	$ 7,645,320
j.	Education	$ 0	$ 0	$ 0	$ 0
k.	Other: Family Planning (T-X)	$ 17,053,435	$ 15,969,893	$ 15,784,668	$ 15,463,523
	Other: NHSCPC/Male Involvement	$ 557,787	$ 398,692	$ 631,433	$ 484,028
III.	**SUB-TOTAL**	$ 528,211,678	$ 507,420,598	$ 527,115,105	$ 499,536,838
		(Line 9, Form 2) and Line 8, Form 3)		(Line 9, Form 2) and Line 8, Form 3)	

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FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I); AND
SOURCES OF OTHER FEDERAL FUNDS(II)
[Sec. 506(a)(2)(iv)]

		FY 2007		FY 2008	
I.	**Federal-State MCH Block Grant Partnership**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a.	Pregnant Women	$ 16,390,937	$ 14,884,859	$ 15,100,565	$
b.	Infants < 1 year old	$ 160,194	$ 145,474	$ 147,582	$
c.	Children 1 to 22 years old	$ 23,185,483	$ 21,055,090	$ 21,360,212	$
d.	CSHCN	$ 40,684,831	$ 36,946,515	$ 37,481,930	$
e.	All Others	$ 7,807,117	$ 7,089,762	$ 7,192,504	$
f.	Administration	$ 9,031,071	$ 8,201,253	$ 8,320,103	$
g.	**SUB-TOTAL**	$ 97,259,632	$ 88,322,953	$ 89,602,895	$ 0
		(Line 7, Form 2 & 3)	(Line 7, Form 3)	(Line 7, Form 2 & 3)	(Line 7, Form 3)
		97,259,632	88,322,953	89,602,895	0
		ck figure			
II.					
a.	SPRANS	$ 0	$ 0	$ 0	$
b.	SSDI	$ 94,570	$ 29,156	$ 94,570	$
c.	CISS	$ 0	$ 0	$ 0	$
d.	Abstinence Education	$ 0	$ 0	$ 0	$
e.	Healthy Start	$ 0	$ 0	$ 0	$
f.	EMSC	$ 0	$ 0	$ 0	$
g.	WIC	$ 512,913,733	$ 473,358,472	$ 512,913,733	$
h.	AIDS	$ 0	$ 0	$ 0	$
i.	CDC	$ 7,155,348	$ 6,425,666	$ 7,190,329	$
j.	Education	$ 0	$ 0	$ 0	$
k.	Other: Family Planning (T-X)	$ 16,365,607	$ 16,322,125	$ 12,024,000	$
	Other: Respite/NHSCPC/Fragile	$ 551,965	$ 535,029	$ 321,670	$
III.	**SUB-TOTAL**	$ 537,081,223	$ 496,670,448	$ 532,544,302	$ 0
		(Line 9, Form 2) and Line 8, Form 3)		(Line 9, Form 2) and Line 8, Form 3)	

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICE
[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]
LAST PAGE UPDATED FOR FY 08

		FY 2003		FY 2004	
		Budgeted	Expended	Budgeted	Expended
I.	**Direct Health Care Services** (Basic Health Services and Health Services for CSHCN)	$ 63,147,001	$ 55,082,125	$ 68,933,101	$ 53,797,636
II.	**Enabling Services** (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management and Coordination with Medicaid, WIC, and Education)	$ 6,518,581	$ 5,686,055	$ 7,472,784	$ 5,832,004
III	**Population Based Services** (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education)	$ 14,842,548	$ 12,946,919	$ 15,367,863	$ 11,993,580
IV	**InfrastructureBuilding Services** (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems)	$ 9,913,410	$ 8,647,310	$ 10,984,655	$ 8,572,782
V	**Total Federal-State Partnership Budget & Expenditures** (Federal-State Partnership only. Item 15g of the SF424. For the "Budgeted" columns this is the same figure that appears in Line 7, Form 2 and in the "Budgeted" columns of Line 7, Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3)	$ 94,421,540	$ 82,362,408	$ 102,758,403	$ 80,196,002
		94,421,540	82,362,407	102,758,402	80,196,002
		ck figure	ck figure	ck figure	ck figure

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FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICE
[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

		FY 2005		FY 2006	
		Budgeted	Expended	Budgeted	Expended
I.	**Direct Health Care Services** (Basic Health Services and Health Services for CSHCN)	$ 68,177,175	$ 56,274,014	$ 69,217,104	$ 59,853,840
II.	**Enabling Services** (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management and Coordination with Medicaid, WIC, and Education)	$ 7,512,942	$ 6,201,246	$ 7,790,923	$ 6,737,015
III	**Population Based Services** (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education)	$ 14,913,774	$ 12,309,955	$ 14,759,162	$ 12,762,633
IV	**InfrastructureBuilding Services** (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems)	$ 10,919,925	$ 9,013,397	$ 11,161,054	$ 9,651,256
V	**Total Federal-State Partnership Budget & Expenditures** (Federal-State Partnership only. Item 15g of the SF424. For the "Budgeted" columns this is the same figure that appears in Line 7, Form 2 and in the "Budgeted" columns of Line 7, Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3)	$ 101,523,816	$ 83,798,612	$ 102,928,243	$ 89,004,743
		101,523,816	83,798,612	102,928,243	89,004,743
		ck figure	ck figure	ck figure	ck figure

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FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICE
[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

		FY 2007		FY 2008	
		Budgeted	**Expended**	**Budgeted**	**Expended**
I.	**Direct Health Care Services** (Basic Health Services and Health Services for CSHCN)	$ 65,659,746	$ 59,626,615	$ 60,256,085	$ 0
II.	**Enabling Services** (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management and Coordination with Medicaid, WIC, and Education)	$ 7,819,741	$ 7,101,226	$ 6,782,290	$ 0
III	**Population Based Services** (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education)	$ 12,996,810	$ 11,802,602	$ 12,848,404	$ 0
IV	**InfrastructureBuilding Services** (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems)	$ 10,783,334	$ 9,792,510	$ 9,716,116	$ 0
V	**Total Federal-State Partnership Budget & Expenditures** (Federal-State Partnership only. Item 15g of the SF424. For the "Budgeted" columns this is the same figure that appears in Line 7, Form 2 and in the "Budgeted" columns of Line 7, Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3)	$ 97,259,631	$ 88,322,953	$ 89,602,896	$ 0
		97,259,632	88,322,953	89,602,895	
		ck figure	ck figure		

FORM 6

NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Sect. 506(a)(2)(B)(iii)

STATE: TX

Total Births by Occurrence: 391,888

Reporting Year: 2006

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria	379,750	96.9	274	12	12	100
Congenital Hypothyroidism	379,750	96.9	7,700	237	237	100
Galactosemia	379,750	96.9	673	7	7	100
Sickle Cell Disease	379,750	96.9	97	97	97	100
Other Screening (Specify)						
Congenital Adrenal Hyperplasia	379,750	96.9	3,926	30	30	100
Sickle Beta Thalassemia	379,750	96.9	42	42	42	100
Sickle-Hemoglobin C Disease	379,750	96.9	21	21	21	100
Screening Programs for Older Children & Women (Specify Tests by name)						
Screening - Vision	2,523,144		214,132	0	0	
Screening - Hearing	2,881,259		52,596	0	0	
Screening - Spinal	683,174		18,992	0	0	

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

FORM NOTES FOR FORM 6

None

FIELD LEVEL NOTES

1. **Section Number:** Main
   Field Name: BirthOccurence
   Row Name: Total Births By Occurence
   Column Name: Total Births By Occurence
   Year: 2008
   Field Note:
   The 2006 occurrence birth number is a preliminary number and subject to change.

2. **Section Number:** Main
   Field Name: SickleCellDisease_Confirmed
   Row Name: SickleCellDisease
   Column Name: Confirmed Cases
   Year: 2008
   Field Note:
   Our screen for Sickle Cell is a diagnostic test therefore the number of presumptive positives will equal the number of diagnosed cases.

3. **Section Number:** Other Screening Types
   Field Name: Other
   Row Name: All Rows
   Column Name: All Columns
   Year: 2008
   Field Note:

4. **Section Number:** Screening Programs for Older Children and Women
   Field Name: OtherWomen
   Row Name: All Rows
   Column Name: All Columns
   Year: 2008
   Field Note:
   Spinal screening shows the statistics for 2004/2005 school year (the most recent data available).

FORM 7

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V
(BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: TX

Reporting Year: 2006

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	**(A) Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private/Other %**	**(E) None %**	**(F) Unknown %**
Pregnant Women	226,089	0.0	0.0	0.0	0.0	100.0
Infants < 1 year old	391,888	0.0	0.0	0.0	0.0	100.0
Children 1 to 22 years old	5,488,402	0.0	0.0	0.0	0.0	100.0
Children with Special Healthcare Needs	79,874	58.3	3.6	12.4	25.7	0.0
Others	174,977	0.0	0.0	0.0	0.0	100.0
TOTAL	6,361,230					

FORM NOTES FOR FORM 7

Note: With the exception of CSHCN, data regarding "primary source of coverage" is not gathered for MCH popuations served.

1. DSHS Maternal and Child Health Contractors Databases (MCH, SDI& TWICES) SFY 2006

2. DSHS, Vital Statistics Unit, Natality Files, Occurrent Births - SFY 2006.

3. CSHCN Services Program contractor reports, DSHS regional staff case management reports, and CSHCN Management Information System.

FIELD LEVEL NOTES

1. **Section Number:** Main
   Field Name: PregWomen_TS
   Row Name: Pregnant Women
   Column Name: Title V Total Served
   Year: 2008
   Field Note:
   Title V is not used to pay for deliveries in Texas. Data for pregnant women and children are estimates. Total includes clients screened by Title V and referred to other funding sources, estimates of the MCH population served by Title V local population based projects designed to eliminate health disparities.

   Sources:
   DSHS Maternal and Child Health Contractors Databases (MCH, TWICES, SDI & Population Based Contractors) SFY 2006

2. **Section Number:** Main
   Field Name: Children_0_1_TS
   Row Name: Infants <1 year of age
   Column Name: Title V Total Served
   Year: 2008
   Field Note:
   Source: Form 6

3. **Section Number:** Main
   Field Name: Children_1_22_TS
   Row Name: Children 1 to 22 years of age
   Column Name: Title V Total Served
   Year: 2008
   Field Note:
   Title V is not used to pay for deliveries in Texas. Data for pregnant women and children are estimates. Total includes clients screened by Title V and referred to other funding sources, estimates of the MCH population served by Title V local population based projects designed to eliminate health disparities, and children in daycare and in kindergarten through 12th grade who have had their vision (FY 2006), hearing screened (FY 2006), and children in 5-12 grade who have received spinal screening (FY 2005 - the most recent available valid data). To avoid duplicative numbers, only Vision and Hearing Screening statistics were added to this item not the Spinal Screening.

   Source: DSHS Maternal and Child Health Contractors Database ; Vision Screening, Hearing Screening & Spinal Screening, SFY 2006.

4. **Section Number:** Main
   Field Name: CSHCN_TS
   Row Name: Children with Special Health Care Needs
   Column Name: Title V Total Served
   Year: 2008
   Field Note:
   The percentages for the Primary Sources of Coverage indicated on this table are derived from multiple datasets. For datasets where the coverage distribution percentages are known, those percentages are employed.

   Sources: CSHCN Services Program contractor reports, DSHS regional staff case management reports, and CSHCN Management Information System.

5. **Section Number:** Main
   Field Name: AllOthers_TS
   Row Name: Others
   Column Name: Title V Total Served
   Year: 2008
   Field Note:
   Clients who receive Family Planning and Dysplasia services. Clients screened by Title V and referred to other funding sources.

   Source:
   DSHS Maternal and Child Health Contractors Database SFY 2006

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX
(BY RACE AND ETHNICITY)
[SEC. 506(A)(2)(C-D)]
STATE: TX

Reporting Year: 2006

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
DELIVERIES								
Total Deliveries in State	395,175	335,261	43,850	923	13,508	164	0	1,469
Title V Served	73,969	62,754	8,208	173	2,529	31	0	274
Eligible for Title XIX	213,879	181,452	23,733	500	7,311	89	0	794
INFANTS								
Total Infants in State	388,317	331,864	41,978	841	12,321	150	0	1,163
Title V Served	391,888	334,916	42,364	849	12,434	151	0	1,174
Eligible for Title XIX	258,583	220,991	27,953	560	8,205	100	0	774

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
DELIVERIES								
Total Deliveries in State	200,021	195,154	0	174,061	343	1,156	10,835	8,759
Title V Served	37,440	36,529	0	32,581	64	216	2,028	1,640
Eligible for Title XIX	108,257	105,622	0	94,207	186	626	5,864	4,739
INFANTS								
Total Infants in State	193,083	195,234	0	174,133	343	1,157	10,839	8,762
Title V Served	194,859	197,029	0	175,734	346	1,167	10,939	8,843
Eligible for Title XIX	128,575	130,008	0	115,956	229	770	7,218	5,835

FORM NOTES FOR FORM 8

Note: The number of infants served by Title V may be larger than the total number of infants due to individuals relocating to Texas after the birth of a child.

FIELD LEVEL NOTES

1. **Section Number:** I. Unduplicated Count By Race
Field Name: DeliveriesTotal_All
Row Name: Total Deliveries in State
Column Name: Total All Races
Year: 2008
Field Note:
This is a projection of the number of infants obtained from Texas State Data Center (Epigram as of 06/15/07). The total number of infants served by Title V is the number of occurrence births in Texas in 2006. The Title V program serves all births, including those from non residents.

2. **Section Number:** I. Unduplicated Count By Race
Field Name: DeliveriesTotal_RaceOther
Row Name: Total Deliveries in State
Column Name: Other and Unknown
Year: 2008
Field Note:
"Total Hispanic and Latino" were added to the "Other and Unknown" category in the previous year.

3. **Section Number:** I. Unduplicated Count By Race
Field Name: InfantsTotal_All
Row Name: Total Infants in State
Column Name: Total All Races
Year: 2008
Field Note:
The total number of "infants served" by Title V is larger than the total number of "infants in state" due to the fact that the number of infants in state is an estimation based on the available data from 1996 throught 2003. The actual number might be larger than the estimated number.

4. **Section Number:** I. Unduplicated Count By Race
Field Name: InfantsTitleV_All
Row Name: Title V Served
Column Name: Total All Races
Year: 2008
Field Note:
The total number of "infants served" by Title V is larger than the total number of "infants in state" due to the fact that the number of infants in state is an estimation based on the available data from 1996 throught 2003. The actual number might be larger than the estimated number.

5. **Section Number:** II. Unduplicated Count by Ethnicity
Field Name: InfantsTotal_TotalNotHispanic
Row Name: Total Infants in State
Column Name: Total Not Hispanic or Latino
Year: 2008
Field Note:
This is a projection of the number of infants obtained from Texas State Data Center (Epigram as of 06/15/07). The totla number of infants served by Title V is the number of occurrence births in Texas in 2005. The Title V program serves all births, including those from non residents.

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TX

	FY 2008	FY 2007	FY 2006	FY 2005	FY 2004
1. State MCH Toll-Free "Hotline" Telephone Number	2-1-1 (Texas Only)	.......211(Texas only)	 211	(800) 422-2956	(800) 422-2956
2. State MCH Toll-Free "Hotline" Name	2-1-1 Texas Information and Referral Network	211 Toll-free Hotline Texas	211 Toll-free Hotline Texas	Family Health Services Information & Referral Line	Family Health Services Information & Referral Line
3. Name of Contact Person for State MCH "Hotline"	Beth Wick	Beth Wick	Beth Wick	Melissa Short	Melissa Short
4. Contact Person's Telephone Number	512-533-2150	512-206-7787	512-206-7787	(512) 458-7329	(512) 458-7329
5. Number of calls received on the State MCH "Hotline" this reporting period	0	0	103,130	60,755	9,982

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TX

	FY 2008	FY 2007	FY 2006	FY 2005	FY 2004
1. State MCH Toll-Free "Hotline" Telephone Number					
2. State MCH Toll-Free "Hotline" Name					
3. Name of Contact Person for State MCH "Hotline"					
4. Contact Person's Telephone Number					
5. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	0	0

FORM NOTES FOR FORM 9

None

FIELD LEVEL NOTES

1. **Section Number:** Main
   Field Name: hname_2
   Row Name: State MCH toll-free hotline name
   Column Name: FY
   Year: 2008
   Field Note:
   www.211texas.org

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2008
[SEC. 506(A)(1)]
STATE: TX

1. State MCH Administration:
(max 2500 characters)

The Texas Department of State Health Services (DSHS) is the state agency responsible for administration of the Title V program and is one of four state health and human service agencies under the umbrella of the Health and Human Services Commission. Within DSHS, the Division for Family and Community Health Services is responsible for most women's and children's programs. The Division administers the Newborn Screening and the Texas Early Hearing Detection and Intervention Program; the Genetic Services Program; the Family Planning Program under Titles V, X, XIX and XX; Texas Health Steps (EPSDT) Medical, Dental, and Medical Case Management; the Children with Special Health Care Needs Services Program (CSHCN SP); the Oral Health Program; the Vision and Hearing Screening Program; the Program for the Amplification for Children of Texas; Women, Infants and Children Nutrition Program (WIC); the Breast and Cervical Cancer Services Program; Title V Women's Health and Child Health Programs; Osteoporosis Awareness and Education; the Primary Health Care Program; and the County Indigent Health Care Program.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 35,207,084
3. Unobligated balance (Line 2, Form 2)	$ 5,170,187
4. State Funds (Line 3, Form 2)	$ 46,447,844
5. Local MCH Funds (Line 4, Form 2)	$ 0
6. Other Funds (Line 5, Form 2)	$ 250,000
7. Program Income (Line 6, Form 2)	$ 2,527,780
8. Total Federal-State Partnership (Line 8, Form 2)	$ 89,602,895

9. Most significant providers receiving MCH funds:

Local health departments, rural health clinics
universities and medical schools, school districts
community-based organizations, FQHCs
case management provider organizations

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	226,089
b. Infants < 1 year old	391,888
c. Children 1 to 22 years old	5,488,402
d. CSHCN	79,874
e. Others	174,977

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

For FY 06, Title V program awarded more than 200 service contracts to local health care providers through a competitive request for proposals process. - In FY 06, a total of 769,461 individuals received health and health-related services from Title V-funded providers and DSHS health service regional offices. - The Title V allowable array of direct and enabling services for reimbursement can be summarized into the following preventive and primary care categories: - Prenatal care services includes initial, return, and postpartum visits; ultrasound; nutrition education; and case management; - Family planning services provides reproductive care services to support and maintain general wellness and reproductive health of low-income women through provision of contraception, health education, annual gynecology examination, and treatment of sexually transmitted diseases; and - Dysplasia services (initial and return visits, colposcopy, biopsy, and conservative treatments for cervical cancer). - Child/adolescent health care includes primary care services for infants, well-child examinations, sick child and follow-up visits, nutritional visits, immunizations, case management; and prenatal care to adolescents. - Dental services for children and adolescents and include periodic oral evaluation, fluoride treatments, sealants and extraction as needed; and - Laboratory testing services are provided free of charge by DSHS laboratory in Austin and the Women's Health Lab in San Antonio to Title V eligible clients through Title V-funded providers.

b. Population-Based Services:
(max 2500 characters)

Current Title V population-based initiatives are arranged into two major categories: those which are implemented through Title V-funded contractors targeting local areas or a group of individuals, and those that are delivered by DSHS central and regional offices, with a statewide impact. All population-based projects are aligned with the purpose of essential public health services in general and that of the Title V program national and state performance measures in particular. - The first category includes population-based projects awarded to local entities through a competitive request for application process in order to address a range of health disparities for minority groups and groups living in rural areas in Texas. Funds for these projects are used to identify and implement best practice strategies for eliminating racial, ethnic, and geographic disparities and to improve birth outcomes in the following areas: low birth weight births, teen pregnancy, adequacy of prenatal care, and STDs. -In FY06, an estimated 5,591,769 individuals received health and health-related services from Title V-funded providers and DSHS health service regional offices. - The second category includes a variety of population-based projects with a statewide impact, delivered by DSHS Central and regional offices. Some major initiatives currently being undertaken are: vision and hearing screening, spinal screening, newborn screening, statewide fluoridation program, school health, and breastfeeding.

c. Infrastructure Building Services:
(max 2500 characters)

DSHS and the Title V program operate within a structure defined by 11 health service regions for the provision of essential public health services to all Texans. Title V program funds several positions based in regional offices to provide: 1) public health services, including core public health services and direct health care, in areas with no local health department (142 out of 254 counties have no public health presence); and 2) technical assistance, contract management, and quality assurance and quality improvement activities for all Title V-funded providers in their assigned regions. - Receive funding for PRAMS, which provides useful data to gain a better understanding of how specific risk factors impact health outcomes. - Implement the Service Delivery Initiative (SDI), which is an infrastructure-building activity designed to integrate the functions of DSHS' health care delivery programs to include policy development, delivery of health services, and contract administration. Currently, 11 contractors with multiple program funding sources

are currently participating in the SDI pilot using an automated system for screening, enrollment, billing, and reporting. In 2008, more Title V-funded contractors will be phased-in into the SDI environment. In addition, the Texas Birth Defects Epidemiology and Surveillance Branch maintains the active surveillance system for the statewide birth defects registry and collaborates with research staff to address findings.

12. The primary Title V Program contact person:

Name	Fouad Berrahou, Ph.D.
Title	State Title V Director
Address	1100 West 49th
City	Austin
State	TX
Zip	78756
Phone	512-458-7321
Fax	512-458-7358
Email	fouad.berrahou@dshs.state.tx.us
Web	www.dshs.state.tx.us

13. The children with special health care needs (CSHCN) contact person:

Name	Lesa Walker, M.D.
Title	State CSHCN Director
Address	1100 West 49th
City	Austin
State	TX
Zip	78756
Phone	512-458-7355
Fax	512-458-7328
Email	lesa.walker@dshs.state.tx.us
Web	www.dshs.state.tx.us

Form Notes for Form 10

None

Field Level Notes

None

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(III) AND 486 (A)(2)(A)(III)]
STATE: TX

Form Level Notes for Form 11

Note that birth and death related data for 2005 and 2006 data are based on a projected linear trend of vital statistics data from 1996 through 2003 (as of 7/16/07.) Note that 2004 birth and death related data were updated as of 9/17/07.

PERFORMANCE MEASURE # 01

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

Annual Objective and Performance Data

	2002	2003	2004	2005	2006
Annual Performance Objective	95	95	95	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	401	426	383	377	370
Denominator	401	426	383	377	370
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100

Annual Indicator
Numerator
Denominator

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Denominator is number of confirmed cases as indicated on Form 6.

2. **Section Number:** Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Denominator is number of confirmed cases as indicated on Form 6.

3. **Section Number:** Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Denominator is number of confirmed cases as indicated on Form 6.

PERFORMANCE MEASURE # 02

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	57	57.1	57.2	57.3	57.4
Annual Indicator	57.0	57.0	57.0	57.0	57.0
Numerator	142,384	142,384	142,384	142,384	142,384
Denominator	249,840	249,840	249,840	249,840	249,840
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	57.5	57.6	57.7	57.8	57.9
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

2. **Section Number:** Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

3. **Section Number:** Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

PERFORMANCE MEASURE # 03

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

	Annual Objective and Performance Data				
	2002	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	58.3	58.4	58.5	58.6	58.7
Annual Indicator	58.3	58.3	58.3	58.3	58.3
Numerator	399,631	399,631	399,631	399,631	399,631
Denominator	685,206	685,206	685,206	685,206	685,206
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Final

	Annual Objective and Performance Data				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	58.8	58.9	59	59.1	59.1
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

2. **Section Number:** Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

3. **Section Number:** Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

PERFORMANCE MEASURE # 04

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	52.9	52.9	52.9	52.9	54
Annual Indicator	52.9	52.9	52.9	52.9	52.9
Numerator	366,173	366,173	366,173	366,173	366,173
Denominator	692,198	692,198	692,198	692,198	692,198
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	54.1	54.2	54.3	54.4	54.5
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

2. **Section Number:** Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

3. **Section Number:** Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

PERFORMANCE MEASURE # 05

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	76.8	76.9	77	77.1	77.2
Annual Indicator	76.8	76.8	76.8	76.8	76.8
Numerator	193,670	193,670	193,670	193,670	193,670
Denominator	252,253	252,253	252,253	252,253	252,253
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	77.3	77.4	77.5	77.6	77.6
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

2. **Section Number:** Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

3. **Section Number:** Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

PERFORMANCE MEASURE # 06

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

Annual Objective and Performance Data

	2002	2003	2004	2005	2006
Annual Performance Objective					5.8
Annual Indicator	5.8	5.8	5.8	5.8	5.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	5.8	5.8	5.8	5.8	5.8
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

2. **Section Number:** Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

3. **Section Number:** Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.
   Since Texas does not have state-specific data or projections at this time, the 2001 and 2002 national average data should be inserted, if needed, for the 2003-2009 projections."

PERFORMANCE MEASURE # 07

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

Annual Objective and Performance Data

	2002	2003	2004	2005	2006
Annual Performance Objective	80	80	80	80	80
Annual Indicator	70.9	77.2	72.5	78.4	79.2
Numerator	358,701				
Denominator	505,925				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	80	80	80	80	80

Annual Indicator
Numerator
Denominator

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source for these data is the National Immunization Survey. Data for 2006 not available at the time of submission. Indicator is a linear estimate based on data from 2002 through 2005.

2. **Section Number:** Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source for these data is the National Immunization Survey - 2005.

3. **Section Number:** Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source of the data is the National Immunization Survey (NIS). NIS is a sample survey. Therefore, numerator and denominator data are not available. Data are abstracted from NIS reports (http://www.cdc.gov/nip/coverage/default.htm#chart).

   Note: 2004 data has been updated to include the hepatitis B vaccine in the set of immunizations.

PERFORMANCE MEASURE # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

	2002	2003	2004	2005	2006
Annual Performance Objective	50	50	50	37	37
Annual Indicator	38.9	37.0	37.9	38.3	37.4
Numerator	18,722	18,271	18,588	19,183	19,108
Denominator	481,349	493,945	490,212	500,489	510,451
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	37	37	37	37	37
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

   Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

   Population data for Texas are provided by the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

3. **Section Number:** Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

PERFORMANCE MEASURE # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	20	21	22	35	35
Annual Indicator	37.5	43.4	54.3	30.8	30.8
Numerator	2,687	1,550	6,468	2,807	2,807
Denominator	7,156	3,572	11,902	9,108	9,108
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	35	35	35	35	35
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The FY06 data is identical to the 2005 data because program staff used 2005 and 2006 to select a randomized sample of third graders from schools with 50% or more free school lunch participation. This sample represents about 70% of the third graders in Texas, but has limited generalizability. In 2007, a new, more sophisticated sample will be drawn. Source, DSHS Statewide Dental Survey. Data reported by the DSHS Oral Health Program.

2. **Section Number:** Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Staff used 2005 and 2006 to select a randomized sample of third graders from schools with 50% or more free school lunch participation. This sample represents about 70% of the third graders in Texas, but has limited generalizability. Source, DSHS Statewide Dental Survey. Data reported by the DSHS Oral Health Program.

3. **Section Number:** Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Despite the FY04 annual indicator, the program has opted to set the target of 35% to reflect the limitation of this measure. The population involved is limited to the reduced/free lunch program.

PERFORMANCE MEASURE # 10

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

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	5.5	5.5	5.5	5.5	5.4
Annual Indicator	5.6	5.4	6.2	5.3	5.2
Numerator	259	259	296	274	276
Denominator	4,647,317	4,752,653	4,768,628	5,185,439	5,284,398
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	5.1	5	5	4.9	4.9
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   This measure is populated with children ages 1 through 14. Population data for Texas are provided by the Center for Health Statistics, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

   Note that 2004 birth and death related data were updated as of 9/17/07 and provisional data for 2005 and 2006 were adjusted based on a projected linear trend of data from 1996 through 2004.

2. **Section Number:** Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Note that 2004 birth and death related data were updated as of 9/17/07 and provisional data for 2005 and 2006 were adjusted based on a projected linear trend of data from 1996 through 2004.

   This measure is populated with children ages 1 through 14. Population data for Texas are provided by the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

3. **Section Number:** Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, data for this measure was entered in 2007 following the availability of actual data for 2004.

   Note that 2004 birth and death related data were updated as of 9/17/07.

PERFORMANCE MEASURE # 11

The percent of mothers who breastfeed their infants at 6 months of age.

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective					38
Annual Indicator				37.5	38
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	38.5	39	39.5	40	40.5
Annual Indicator **Numerator** **Denominator**	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				

Field Level Notes

1. **Section Number:** Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The percentage for 2006 was estimated based on the final data from 2003 through 2005. TVIS did not allow change in the annual incators for the previous years. The final percentage for the previous years were:
   Year 2003 -- 33.8
   Year 2004 -- 37.5
   Year 2005 -- 36.5

   Source for data is 2005 National Immunization Survey. Numerator and denominator data are not available.

2. **Section Number:** Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source for data is 2004 National Immunization Survey. Numerator and denominator data are not available.

PERFORMANCE MEASURE # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective	92	92	92	90	90
Annual Indicator	84.3	82.1	89.2	89.8	91.2
Numerator	313,116	309,701	340,427	345,394	357,595
Denominator	371,429	377,374	381,441	384,465	391,888
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	92	92	92	92	92
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source for the numerator is the Texas Department of State Health Services Newborn Hearing Screening Database. The denominator is a projection of total live births using vital statistics data from 1991 to 2003 (as of 7/16/07).

2. **Section Number:** Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source for the numerator is the Texas Department of State Health Services Newborn Hearing Screening Database. The denominator is a projection of total live births using vital statistics data from 1991 to 2003 (as of 7/16/07.)

3. **Section Number:** Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for denominator was entered in 2007 following the availability of the 2004 data.

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

	2002	2003	2004	2005	2006
	Annual Objective and Performance Data				
Annual Performance Objective	22	20	20	20	20
Annual Indicator	22.4	20.0	20.4	18.9	20.0
Numerator	1,341,023	1,264,446	1,279,078	1,224,279	1,272,530
Denominator	5,986,708	6,330,256	6,263,325	6,476,859	6,362,648
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

	2007	2008	2009	2010	2011
	Annual Objective and Performance Data				
Annual Performance Objective	19.9	19.6	19.3	18.9	18.3
Annual Indicator / **Numerator** / **Denominator**	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				

Field Level Notes

1. **Section Number:** Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Provisional data based on population projection from DSHS Epigram and estimated numerator.

2. **Section Number:** Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source: U.S. Census Bureau,
   Current Population Survey, Annual Social and Economic Supplement, 2006

   CPS Table Creator for all persons 0 to 17 for variable Health Insurance Coverage. Both numerator and denominator are drawn from this source.

   http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

3. **Section Number:** Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: U.S. Census Bureau,
   Current Population Survey, Annual Social and Economic Supplement, 2005

   CPS Table Creator for all persons 0 to 17 for variable Health Insurance Coverage. Both numerator and denominator are drawn from this source.

   http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

PERFORMANCE MEASURE # 14

Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					23
Annual Indicator				23.7	23.9
Numerator				162,380	160,793
Denominator				683,968	671,445
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	22	22	21	20	20
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source: WIC Database, Office of Title V and Family Health

2. **Section Number:** Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source: WIC Database, Office of Title V and Family Health Planning

PERFORMANCE MEASURE # 15

Percentage of women who smoke in the last three months of pregnancy.

Annual Objective and Performance Data

	2002	2003	2004	2005	2006
Annual Performance Objective					7.3
Annual Indicator				7.4	7.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	7.2	7.1	7	6.9	6.8
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source: The source for this provisional data is PRAMS. Final and future reports will come from the Texas birth certificate which will include questions about smoking by trimester.

2. **Section Number:** Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   The source for this provisional data is PRAMS. Final and future reports will come from the Texas birth certificate which will include questions about smoking by trimester.

PERFORMANCE MEASURE # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	10.5	10	10	9	7.8
Annual Indicator	9.0	9.5	7.9	7.9	7.6
Numerator	149	162	136	138	136
Denominator	1,653,654	1,701,620	1,726,142	1,752,098	1,786,854
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	7.6	7.4	7.2	7	7
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #16
Field Name: PM16
Row Name:
Column Name:
Year: 2006
Field Note:
Note that 2004 birth and death related data were updated as of 9/17/07 and provisional data for 2005 and 2006 were adjusted based on a projected linear trend of data from 1996 through 2004.

   Population data for Texas are provided by the Center for Health Statistics, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Performance Measure #16
Field Name: PM16
Row Name:
Column Name:
Year: 2005
Field Note:
Note that 2004 birth and death related data were updated as of 9/17/07 and provisional data for 2005 and 2006 were adjusted based on a projected linear trend of data from 1996 through 2004.

   Population data for Texas are provided by the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

3. **Section Number:** Performance Measure #16
Field Name: PM16
Row Name:
Column Name:
Year: 2004
Field Note:
Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 9/17/07 following the availability of actual data for 2004.

PERFORMANCE MEASURE # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	55	55	55	55	55
Annual Indicator	53.5	52.4	48.8	52.9	53.3
Numerator	2,660	2,690	2,674	2,827	2,889
Denominator	4,976	5,133	5,482	5,342	5,417
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	55	55	55	55	55
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source: Very Low Birth Weight deliveries data is from DSHS, Bureau of Vital Statistics, Natality Files, 1996 - 2003.

   Estimated data is based on 1996-2003 data (as of 7/16/07).

2. **Section Number:** Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source: Very Low Birth Weight deliveries data is from DSHS, Bureau of Vital Statistics, Natality Files, 1996 - 2003.

   Estimated data is based on 1996-2003 data (as of 7/16/07).

3. **Section Number:** Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

PERFORMANCE MEASURE # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective	85	85	85	85	85
Annual Indicator	79.3	79.7	81.6	82.0	82.2
Numerator	295,282	300,927	311,089	315,443	322,754
Denominator	372,369	377,374	381,441	384,465	392,830
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	85	85	85	85	85
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Estimated data is based on 1996-2003 data (as of 7-16-07)

2. **Section Number:** Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Estimated data is based on 1996-2003 data (as of 7-16-07)

3. **Section Number:** Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

STATE PERFORMANCE MEASURE # 1

Change in percentage of CSHCN living in congregate care settings as percent of base year 2003

Annual Objective and Performance Data

	2002	2003	2004	2005	2006
Annual Performance Objective					95
Annual Indicator				99.3	100.1
Numerator				1,606	1,619
Denominator				1,617	1,617
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	90	85	82	80	80
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source: Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2006.

   The FY06 number exceeds the base year 2003. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments.

2. **Section Number:** State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Correction to data obtained from Health and Human Services Commission Report.
   The number reported for 2005 should be changed from 1587 to 1606.

STATE PERFORMANCE MEASURE # 2

The percent of obesity among women ages 18 to 44

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective					23
Annual Indicator				23.6	24.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	22.5	22	21.5	21	20.5
Annual Indicator Numerator Denominator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				

Field Level Notes

1. **Section Number:** State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

2. **Section Number:** State Performance Measure #2
   Field Name: SM2
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

STATE PERFORMANCE MEASURE # 3

Percent of licensed child care centers in metropolitan counties that have no deficiencies in operational policies that address health and safety of children.

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					90
Annual Indicator				0.0	
Numerator				0	
Denominator				55	7,500
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	90	90.5	91	91.5	92

Annual Indicator
Numerator
Denominator

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   The measure has been refined based on review of activities in FY07. Numerator is not available at this time.

   Denominator is an estimate of total licensed child care centers in metropolitan areas.

2. **Section Number:** State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source: http://www.tea.state.tx.us/student.assessment/reporting/results/swresults/taks/2006/g3e.pdf

   Texas Education Agency, Student Assessment Division

STATE PERFORMANCE MEASURE # 4

The proportion of women between the ages of 18 and 44 who are current cigarette smokers.

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective					17.5
Annual Indicator				18	15.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	17	16.5	16	15.5	15
Annual Indicator Numerator Denominator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				

Field Level Notes

1. **Section Number:** State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

2. **Section Number:** State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   BRFSS is a sample survey. Therefore, numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting.

STATE PERFORMANCE MEASURE # 5

The prevalence of at-risk for obesity and obesity among adolescents enrolled in high school

Annual Objective and Performance Data

	2002	2003	2004	2005	2006
Annual Performance Objective					28
Annual Indicator				29	29
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	27	26	25	24	23
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source: Texas, 2005 Youth Risk Behavior Survey (YRBS) Results. http://www.cdc.gov/HealthyYouth/yrbs/pdf/mortality/texas.pdf

2. **Section Number:** State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Estimate is based on 2005 YRBS. Since YRBS is a sample survey, numerator and denominator data are not applicable.

   Source: Texas, 2005 Youth Risk Behavior Survey (YRBS) Results. http://www.cdc.gov/HealthyYouth/yrbs/pdf/mortality/texas.pdf

STATE PERFORMANCE MEASURE # 6

The percent of children provided preventive dental services.

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective					42
Annual Indicator				41.5	40.0
Numerator				1,051,633	1,047,804
Denominator				2,532,422	2,620,912
Is the Data Provisional or Final?				Final	Final

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	42.5	43	43.5	44	44.5
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source: TMHP, HISR303A, SFY 2006 Final (AHMST081).

2. **Section Number:** State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source: TMHP, HISR303A, SFY 2005 Final (AHMST081).

   Data are for the State Fiscal Year (September - August).

   Preventive services include all ADA preventive codes, D1000-D1999.

STATE PERFORMANCE MEASURE # 7

Rate of family violence incidents involving females victims per 1,000 women in Texas

Annual Objective and Performance Data

	2002	2003	2004	2005	2006
Annual Performance Objective					11.9
Annual Indicator				12.1	12.8
Numerator				136,383	150,602
Denominator				11,268,054	11,734,914
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2007	2008	2009	2010	2011
Annual Performance Objective	11.7	11.5	11.3	11.1	11.1
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Provisional data are lagged one calendar year.

   Source: http://www.txdps.state.tx.us/crimereports/04/cit04ch5.pdf from the Texas Department of Public Safety.

2. **Section Number:** State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Provisional data are lagged one calendar year. Source: http://www.txdps.state.tx.us/crimereports/04/cit04ch5.pdf from the Texas Department of Public Safety.

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (A)(2)(B)(III) AND 506 (A)(2)(A)(III)]
STATE: TX

Form Level Notes for Form 12

2005 and 2006 data are based on a projected linear trend of vital statistics data from 1996 through 2003 (as of 7/16/07.) Note that 2004 birth and death related data were updated as of 9/17/07.

OUTCOME MEASURE # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5
Annual Indicator	6.4	6.6	6.3	5.7	5.5
Numerator	2,369	2,483	2,398	2,186	2,176
Denominator	372,369	377,374	381,441	384,465	392,830
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

2. **Section Number:** Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

3. **Section Number:** Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

OUTCOME MEASURE # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7
Annual Indicator	2.4	2.4	2.3	2.5	2.5
Numerator	13.5	13.8	12.8	11.8	11.7
Denominator	5.7	5.8	5.6	4.8	4.6
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Ratio is based on data projected on a linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

2. **Section Number:** Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Ratio is based on data projected on a linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

3. **Section Number:** Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

OUTCOME MEASURE # 03

The neonatal mortality rate per 1,000 live births.

	Annual Objective and Performance Data				
	2002	**2003**	**2004**	**2005**	**2006**
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5
Annual Indicator	3.9	4.4	4.1	3.7	3.6
Numerator	1,452	1,649	1,574	1,405	1,409
Denominator	372,369	377,374	381,441	384,465	392,830
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2007	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

2. **Section Number:** Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

3. **Section Number:** Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

OUTCOME MEASURE # 04

The postneonatal mortality rate per 1,000 live births.

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective	2.5	2.4	2.4	2.4	2.4
Annual Indicator	2.5	2.2	2.2	2.0	2.0
Numerator	917	834	824	781	767
Denominator	372,369	377,374	381,441	384,465	392,830
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	2.4	2.4	2.4	2.4	2.4
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

2. **Section Number:** Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

3. **Section Number:** Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

OUTCOME MEASURE # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective	9	9	8.9	8.9	8.9
Annual Indicator	9.5	10.0	10.1	9.1	8.9
Numerator	3,560	3,777	3,860	3,513	3,524
Denominator	374,477	379,502	383,727	386,331	395,175
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	8.9	8.9	8.9	8.9	8.9
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

2. **Section Number:** Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

3. **Section Number:** Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

OUTCOME MEASURE # 06

The child death rate per 100,000 children aged 1 through 14.

	Annual Objective and Performance Data				
	2002	2003	2004	2005	2006
Annual Performance Objective	23.1	23.1	23.1	23.1	23.1
Annual Indicator	23.5	24.4	23.2	21.8	19.8
Numerator	1,094	1,155	1,099	1,062	1,047
Denominator	4,647,317	4,725,653	4,728,000	4,881,466	5,284,398
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2007	2008	2009	2010	2011
Annual Performance Objective	23.1	23.1	23.1	23.1	23.1
Annual Indicator **Numerator** **Denominator**	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				

Field Level Notes

1. **Section Number:** Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (as of 7/16/07).
   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

3. **Section Number:** Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

STATE OUTCOME MEASURE # 1

The ratio of the Black perinatal mortality rate to the White perinatal mortality rate.

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	1	1	1	1	1
Annual Indicator	2.0	2.2	2.3	2.4	2.3
Numerator	18	20	18	19	18
Denominator	9	9	8	8	8
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	1	1	1	1	1
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (most recent available).

2. **Section Number:** State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 2002 and 2003 (most recent available) and projected 2004.

3. **Section Number:** State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1991 through 2003 (most recent available).

FORM 13
CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS
STATE: TX

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

2

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

2

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

2

4. Family members are involved in service training of CSHCN staff and providers.

1

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

0

6. Family members of diverse cultures are involved in all of the above activities.

2

Total Score: 9

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

FORM NOTES FOR FORM 13

Note:
1. Reflects the family member participation in contractor advisory committees as well as a broad range of statewide interagency advisory committees or task forces spearheaded by DSHS or other agencies.

5. Although no staff members are hired specifically because of their role as a family member, several staff members within the Purchased Health Services Unit are family members and/or caregivers for adolescents or young adults with special health care needs.

FIELD LEVEL NOTES

None

FORM 14
LIST OF MCH PRIORITY NEEDS

[Sec. 505(a)(5)]

STATE: TX FY: 2008

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

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

FORM NOTES FOR FORM 14

Improve the organization and coordination of community-based service systems for CSHCN and their families so that an increased number of families of CSHCN report that these systems are easy to use.

FIELD LEVEL NOTES

None

FORM 15
TECHNICAL ASSISTANCE(TA) REQUEST

STATE: TX **APPLICATION YEAR: 2008**

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**General Systems Capacity Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	An analysis of states' policies/procedures related to employment criteria that specify a critical job component for an applicant to be a parent or family member of a child or youth with special health care needs.	It is unclear how to legally require a state empoyee to be a parent or family member of a child with special health care needs to provide consultation to the agency.	HRSA
2.	**National Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 9	Identify best practices in providing and promoting oral health, a plan for implementing training for providers for pediatric oral health care.	There is currently a shortage of pediatric and general dentists to provide oral health care to children.	unknown
3.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
4.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
5.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
9.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the			

	measure number here: _______			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _______			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _______			

FORM NOTES FOR FORM 15

None

FIELD LEVEL NOTES

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: TX

SP # 1

PERFORMANCE MEASURE:	Change in percentage of CSHCN living in congregate care settings as percent of base year 2003
STATUS:	Active
GOAL	All CSHCN live in families, in communities, consistent with permanency planning principles.
DEFINITION	Change in percentage of CSHCN living in congregate care settings as percent of base year 2003 **Numerator:** Number of CSHCN living in congregate care settings at the end of the current year **Denominator:** Number of CSHCN living in congregate care in base year (2003) **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 6-7 Reduce the number of people with disabilities in congregate care facilities, consistent with permanency planning principles. Target 6-7b: Zero persons aged 21 years and under in congregate care facilities.
DATA SOURCES AND DATA ISSUES	Data source: State Health and Human Services Commission - Office of Program Coordination for Children and Youth. Data issues: Starting in FY04, as indicated above and on Form 11, the denominator for this performance measure was changed to reflect data from a base year of 2003 (instead of the data from the previous year). Also, to improve data accuracy, the count of children in congregate care settings for the base year and future years was expanded to include children in Home and Community Services group homes and Department of Family and Protective Services institutions in addition to those in state schools, Intermediate Care Facilities (MR), and in nursing homes.
SIGNIFICANCE	Many children with activity limitations, cognitive impairments, or behavioral conditions, need ongoing and long-term assistance that may be (or may have been) available only in congregate care settings. On 8/31/2004, there were children who were institutionalized in state schools, Intermediate Care Facilities (MR), Home and Community Services group homes, Department of Family and Protective Services institutions, and nursing homes. Every CSHCN belongs in a family with a consistent caregiver who takes responsibility for the child's growth, development, and overall well-being. CSHCN still reside in nursing homes and other congregate care settings. Families with CSHCN need family support services and care options so that CSHCN can remain in families within the community.

SP # 2

PERFORMANCE MEASURE:	The percent of obesity among women ages 18 to 44
STATUS:	Active
GOAL	Decrease the percent of obese women in Texas ages 18 to 44.
DEFINITION	% of obese women ages 18 to 44 **Numerator:** Numerator: Obese women 18 - 44 years old who report a Body Mass Index (BMI) of 30.0 or more. **Denominator:** Denominator: Women 18 to 44 years old. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Behavior Risk Factor Surveillance Survey (BRFSS)
SIGNIFICANCE	Some data show a link between obesity during pregnancy and the incidence of neural tube defects, some of which can be fatal or can severely compromise the child. There is also some data that indicate that when the mother is obese, there is higher risk of prematurity, delivery complications and cesarean delivery, all of which can potentially lead to increased perinatal, infant, neonatal, postneonatal and child mortality. Furthermore, since the incidence of obesity is high among African American women, it can play a role in the infant death disparity. Obesity can also impact women's mobility and overall health status. Decreasing the rate of obesity in women in Texas will have a positive impact on maternal, perinatal and child health outcomes.

SP # 3

PERFORMANCE MEASURE:	Percent of licensed child care centers in metropolitan counties that have no deficiencies in operational policies that address health and safety of children.
STATUS:	Active
GOAL	To improve children's readiness for school.
DEFINITION	Percentage of licensed child care centers in metropolitan counties with complete operational procedures that address health and safety of children in care. **Numerator:** Number of licensed child care centers in metropolitan counties with complete operational procedures that address health and safety of children in care. **Denominator:** Number of licensed child care centers in metropolitan counties. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	This is planned as a two year developmental measure that will allow Texas to track progress of the infrastructure building needed to have a significant impact on children in day care programs in Texas. Data from the Child Care Licensing Division of the Texas Department of Family and Protective Services will be used.
SIGNIFICANCE	A significant proportion of Texas' children encounter the day care system. Daycare is a leverage point that can be used to educate and monitor children's health status and readiness for school.

SP # 4

PERFORMANCE MEASURE:	The proportion of women between the ages of 18 and 44 who are current cigarette smokers.
STATUS:	Active
GOAL	Decrease the rate of current cigarette smoking among women 18 to 44.
DEFINITION	% of women ages 18 to 44 who are current cigarette smokers **Numerator:** Number of women between the ages of 18 to 44 who report smoking everyday or somedays **Denominator:** Number of women between the ages of 18 to 44 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Behavior Risk Factor Surveillance Survey (BRFSS)
SIGNIFICANCE	Data link fetal exposure to tobacco to prematurity, low birth weight, Sudden Infant Death Syndrome and asthma and other respiratory problems, all of which can increase perinatal, infant, neonatal, postneonatal and child mortality. Reducing the rate of women of childbearing age that smoke in Texas will have a positive impact on perinatal and child health outcomes.

SP # 5

PERFORMANCE MEASURE:	The prevalence of at-risk for obesity and obesity among adolescents enrolled in high school
STATUS:	Active
GOAL	To assure that families and communities promote healthy eating and increased physical activity patterns among young adults.
DEFINITION	**Numerator:** Number of obese (>95 percentile BMI) and at risk for obese (>85 percentile BMI) adolescents among high school students **Denominator:** Number of high school students in Texas **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Texas YRBS
SIGNIFICANCE	Obesity is the most common disorder of childhood in the developed world, and its prevalence is still increasing. There are substantial risks for morbidity in obese children even before they reach adulthood. Overweight during adolescence affects blood pressure and blood lipid, lipoprotein, and insulin levels in adolescents. Perhaps the most widespread consequences of childhood and adolescent obesity are psychosocial, including discrimination. If obesity in childhood persists into the adult years, the morbidity and mortality is greater than if the obesity developed in the adult. Longitudinal studies of children followed into young adulthood suggest that overweight children may become overweight adults, particularly if obesity is present during adolescence.

SP # 6

PERFORMANCE MEASURE:	The percent of children provided preventive dental services.
STATUS:	Active
GOAL	Increase access to dental service among children 1-20 years of age.
DEFINITION	**Numerator:** Numerator: Number children age 1-20 who received preventive dental treatments (includes fluoride, sealants, space maintainers) under the Texas Health Steps (THSteps) Program **Denominator:** Denominator: Number children age 1-20 eligible for dental services under the Texas Health Steps (THSteps) Program **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	State Medicaid Data
SIGNIFICANCE	To address the needs relating to dental health, the Oral Health Program implementation of a statewide oral health coalition and the expansion of services offers a venue to assess, plan, and implement measures that will ultimately impact dental health prevention activities.

SP # 7

PERFORMANCE MEASURE:	Rate of family violence incidents involving females victims per 1,000 women in Texas
STATUS:	Active
GOAL	Increase detection of and appropriate responses to women and adolescents seeking health services who are suspected victims of relationship abuse.
DEFINITION	**Numerator:** Number of family violence incidents involving women of all ages **Denominator:** Total population of women in Texas **Units:** 1000 **Text:** Rate
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Numerator: Dept. of Public Safety Records. Denominator: Population data.
SIGNIFICANCE	Relationship violence often results in emergency room visits, physician office visits, hospitalization, lost days of work, mental or emotional problems or death. In 2003, 153 women were killed by their partners (Texas Department of Public Safety). Current studies show that 47 percent of Texans experience some form of domestic violence in their lifetimes and that 26 percent of Texans experience severe physical abuse from an intimate partner (Saurage, 2003). The first statewide survey of sexual assault ever conducted revealed that 1.9 million Texans have been sexually assaulted during their lifetimes, with females four times more likely than males to experience sexual assault (Busch, Bell, DiNitto, Jeff, 2003). DSHS is committed in helping to prevent interpersonal violence and abuse. Screening patients for abuse should become standard procedure with women and adolescents. Title V will assist with that process by making screening tools available on the internet. Providers have been and will continue to be trained to work closely with family violence and sexual assault prevention service providers in their areas of the state and are encouraged to collaborate on community prevention projects beyond cross referrals.

SO # 1

OUTCOME MEASURE:	The ratio of the Black perinatal mortality rate to the White perinatal mortality rate.
STATUS:	Active
GOAL	To reduce the disparity (ratio) between the Balck and White perinatal mortality.
DEFINITION	**Numerator:** The Black perinatal mortality rate per 1,000 live births. **Denominator:** The White perinatal mortality rate per 1,000 live births. **Units:** 1 **Text:** Ratio
HEALTHY PEOPLE 2010 OBJECTIVE	
DATA SOURCES AND DATA ISSUES	Vital records collected by the State.
SIGNIFICANCE	Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care. Overall, there were 3,445 or 9.8 per 1,000 live births perinatal deaths in 1999. These deaths revealed a significant racial disparity. The disparity rate for Black perinatal mortality rate (11 per 1,000 live births) is almost twice the White rate of 6 per 1,000 live births. Black women are twice as likely as White women to experience low birth weight, neonatal and fetal deaths.

FORM NOTES FOR FORM 16

None

FIELD LEVEL NOTES

1. **Section Number:** State Performance Measure 1
Field Name: SPM1
Row Name:
Column Name:
Year: 2008
Field Note:
Data source: HHSC Permanency Planning and Family-Based Alternatives Report - submitted to the Governor and Legislature December 2006.

The FY06 number exceeds the base year 2003. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments.

Correction made to FY05: The number reported for 2005 should be changed from 1587 to 1606.

2. **Section Number:** State Performance Measure 3
Field Name: SPM3
Row Name:
Column Name:
Year: 2008
Field Note:
Measure refined to provide greater focus on health and health-related activities.

FORM 17
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07 & 08 - MULTI-YEAR DATA
STATE: TX

Form Level Notes for Form 17

2005 and 2006 data are based on a projected linear trend of vital statistics data from 1996 through 2003 (as of 7/16/07.) Note that 2004 birth and death related data were updated as of 9/17/07.

HEALTH SYSTEMS CAPACITY MEASURE # 01

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

	Annual Indicator Data				
	2002	**2003**	**2004**	**2005**	**2006**
Annual Indicator	38.8	35.7	34.4	25.9	24.2
Numerator	6,520	6,115	6,161	4,745	4,566
Denominator	1,680,867	1,712,778	1,793,350	1,835,331	1,883,567
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data is an estimate based on a linear trend of 2002 through 2005.

2. **Section Number:** Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data is an estimate based on a linear trend of 2001 through 2004.

3. **Section Number:** Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Sources:
   Hospitalizations - Texas Hospital Inpatient Discharge Public Use Data File. Texas Health Care Information Council (THCIC), Austin, TX, 2004.

   The 2000-2004 data is based on hospitalizations, not individuals. These numbers may be an underestimation of the true rate of hospitalizations for asthma because Texas hospitals located in counties with populations less than 35,000 are exempt from reporting to the THCIC.

   Population - Texas State Data Center, Texas Population Estimates and Projections, June 2006.

HEALTH SYSTEMS CAPACITY MEASURE # 02

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

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	70.6	93.5	98.7	96.4	100.0
Numerator	158,431	223,304	245,083	244,236	258,808
Denominator	224,388	238,851	248,232	253,418	258,808
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   100% reported on CMS-416. Numerator and denominator had slight differences due to data reporting system.

   Source:
   Texas CMS-416 FFY 2005 - 2006

2. **Section Number:** Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Notes:
   The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

   Source:
   Texas CMS-416 FFY 2004 - 2005

3. **Section Number:** Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Notes:
   The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

   Source:
   Texas CMS-416 FFY 2003 - 2004

HEALTH SYSTEMS CAPACITY MEASURE # 03

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

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	2.0	0.7	0.4	41.7	38.5
Numerator	14,549	5,407	2,823	1,600	1,243
Denominator	727,452	727,434	651,054	3,837	3,226
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Prior to 2005, denominator data included all Texas SCHIP recipients.

   Source:
   Texas Health and Human Services Commission (HHSC).

2. **Section Number:** Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Prior to 2005, denominator data included all Texas SCHIP recipients.

3. **Section Number:** Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Sources:
   2002 - Texas Health & Human Services, Children's Health Insurance Program in Texas.: The New Enrollee Survey Report 2003, March 2003.
   Centers for Medicare and Medicaid Services, SCHIP Preliminary Annual Enrollment Report for Fiscal year 2002. http//www.cms.hhs.gov/schip/enrollment

   2003 - 2004 Update: Texas Health & Human Services Commission.

HEALTH SYSTEMS CAPACITY MEASURE # 04

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

	Annual Indicator Data				
	2002	2003	2004	2005	2006
Annual Indicator	69.7	70.3	69.9	74.8	79.3
Numerator	258,393	265,305	265,673	292,636	311,358
Denominator	370,983	377,374	380,056	391,482	392,830
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data is a linear trend projection using data from 2001 through 2005 (as of 7/16/07.)

2. **Section Number:** Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data is a linear trend projection using data from 2001 through 2004 (as of 7/16/07.)

3. **Section Number:** Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

HEALTH SYSTEMS CAPACITY MEASURE # 07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	55.4	60.0	62.1	62.9	64.5
Numerator	846,963	1,098,882	1,253,626	1,317,797	1,370,299
Denominator	1,529,942	1,831,982	2,017,859	2,095,657	2,123,317
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source:
   CMS-416 FFY 1997-2006

2. **Section Number:** Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source:
   CMS-416 FFY 1997-2005

3. **Section Number:** Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source:
   CMS-416 FFY 1997-2004

HEALTH SYSTEMS CAPACITY MEASURE # 07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	51.4	55.2	56.0	56.3	55.2
Numerator	194,057	250,718	287,357	301,346	308,987
Denominator	377,746	454,423	512,778	535,079	559,406
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Source:
   Texas CMS-416 FFY 2006.

2. **Section Number:** Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Source:
   Texas CMS-416 FFY 2005.

3. **Section Number:** Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source:
   Texas CMS-416 FFY 2004.

HEALTH SYSTEMS CAPACITY MEASURE # 08

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

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	68.5	NaN	54.6	47.3	25.1
Numerator	31,289	0	35,758	35,758	21,088
Denominator	45,689	0	65,476	75,528	83,891
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Total SSI Recipients under 16
   Source: SSA, Supplemental Security Record - December 2006

   Total SSI Recipients under 16 Receiving Rehabilitation Services
   Source: from the Health Screening and Case Management Unit and the Purchased Health Services Unit for the CSHCN Services Program.

2. **Section Number:** Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   All SSI recipients in Texas obtain health care benefits coverage through Medicaid. Considering the broader spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach and case management services through CSHCN Title V efforts.

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #05
(MEDICAID AND NON-MEDICAID COMPARISON)
STATE: TX

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
a) *Percent of low birth weight (< 2,500 grams)*	2003	Payment source from birth certificate	8.1	7.5	7.9
b) *Infant deaths per 1,000 live births*	2003	Payment source from birth certificate	7.7	6	6.6
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2003	Payment source from birth certificate	75.2	82.2	79.7
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2003	Payment source from birth certificate	70.1	70.5	70.4

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(MEDICAID ELIGIBILITY LEVEL)
STATE: TX

INDICATOR #06 ***The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)**
a) *Infants (0 to 1)*	2006	185
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 18) (Age range 19 to 20)	2006	 133 100 100
c) *Pregnant Women*	2006	185

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(SCHIP ELIGIBILITY LEVEL)
STATE: TX

INDICATOR #06 ***The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
a) *Infants (0 to 1)*	2006	200
b) *Medicaid Children* (Age range 1 to 18) (Age range ___ to ___) (Age range ___ to ___)	2006	 200
c) *Pregnant Women*		200

FORM NOTES FOR FORM 18

None

FIELD LEVEL NOTES

1. **Section Number:** Indicator 06 - Medicaid
Field Name: Med_Infant
Row Name: Infants
Column Name:
Year: 2008
Field Note:
Sources:

Selected HHS Program-Related Percent of Federal Poverty Income Levels (FPL's) for 2006

(http://www.hhsc.state.tx.us/research/dssi/PS/PgmPovertyLevels.html).

Based on Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia, Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Prepared by: DSHS, FCHS-HDAR, February 2006. Data was rounded up as specified by CMS/HHS directive.

2. **Section Number:** Indicator 06 - Medicaid
Field Name: Med_Children
Row Name: Medicaid Children
Column Name:
Year: 2008
Field Note:
Medicaid recipients who are 19-20 either qualify for SSI and receive Medicaid, or are in transitional groups including youth transitioning from foster care.

Non-disabled, non-pregnant adults under age 65 must be parents and/or related caretakers of children with income below the TANF limit to receive Medicaid benefits. Children under age 19 and pregnant women with income over the limit who have medical bills that, if deducted from income, reduce income to a specified income limit ($275 per month and assets under $2,000 for a family of three), may be eligible for Medicaid coverage of additional medical bills. A straight percentage of the FPL is not used. Data system would not allow entry of a number below 100%.

3. **Section Number:** Indicator 06 - Medicaid
Field Name: Med_Women
Row Name: Pregnant Women
Column Name:
Year: 2008
Field Note:
Sources:

Selected HHS Program-Related Percent of Federal Poverty Income Levels (FPL's) for 2006

(http://www.hhsc.state.tx.us/research/dssi/PS/PgmPovertyLevels.html).

Based on Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia, Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Prepared by: DSHS, FCHS-HDAR, February 2006. Data was rounded up as specified by CMS/HHS directive.

4. **Section Number:** Indicator 06 - SCHIP
Field Name: SCHIP_Infant
Row Name: Infants
Column Name:
Year: 2008
Field Note:
Sources:

Selected HHS Program-Related Percent of Federal Poverty Income Levels (FPL's) for 2006

(http://www.hhsc.state.tx.us/research/dssi/PS/PgmPovertyLevels.html). Based on Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia, Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Prepared by: DSHS, FCHS-HDAR, February 2006. Data was rounded up as specified by CMS/HHS directive.

5. **Section Number:** Indicator 06 - SCHIP
Field Name: SCHIP_Children
Row Name: SCHIP Children
Column Name:
Year: 2008
Field Note:
To qualify for CHIP, a child must be under age 19.

As of 1/2/07, CHIP began providing a perinatal benefit to unborn children of pregnant women who do not qualify for Medicaid, with income up to 200% FPL, and who meet the other eligibility requirements.

6. **Section Number:** Indicator 06 - SCHIP
Field Name: SCHIP_Women
Row Name: Pregnant Women
Column Name:
Year: 2008
Field Note:
On 1/2/07, A new benefit of CHIP extended coverage for an unborn child of non-Medicaid eligible women for up to 12 months. To be eligible the income must be below 200% FPL.

7. **Section Number:** Indicator 05
Field Name: LowBirthWeight
Row Name: Percent of ow birth weight (<2,500 grams)
Column Name:
Year: 2008
Field Note:
The most current available birth record for the State of Texas is 2003.

8. **Section Number:** Indicator 05

Field Name: InfantDeath
Row Name: Infant deaths per 1,000 live births
Column Name:
Year: 2008
Field Note:
The most current available birth record for the State of Texas is 2003.

9. **Section Number:** Indicator 05
   Field Name: CareFirstTrimester
   Row Name: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
   Column Name:
   Year: 2008
   Field Note:
   The most current available birth record for the State of Texas is 2003.

10. **Section Number:** Indicator 05
    Field Name: AdequateCare
    Row Name: Percent of pregnant women with adequate prenatal care
    Column Name:
    Year: 2008
    Field Note:
    The most current available birth record for the State of Texas is 2003.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TX

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Informatioin)

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) *	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TX

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

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

Form Notes for Form 19

None

Field Level Notes

None

FORM 20
HEALTH STATUS INDICATORS #01-#05
MULTI-YEAR DATA
STATE: TX

Form Level Notes for Form 11

2005 and 2006 data are based on a projected linear trend of vital statistics data from 1996 through 2003 (as of 7/16/07.) Note that 2004 birth and death related data were updated as of 9/17/07.

HEALTH STATUS INDICATOR MEASURE # 01A

The percent of live births weighing less than 2,500 grams.

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	7.7	7.9	8.0	7.9	8.1
Numerator	28,649	29,727	30,647	31,143	31,991
Denominator	372,369	377,374	381,441	394,687	392,830
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

2. **Section Number:** Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

3. **Section Number:** Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

HEALTH STATUS INDICATOR MEASURE # 01B

The percent of live singleton births weighing less than 2,500 grams.

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	6.2	6.3	6.4	6.3	6.4
Numerator	22,255	23,187	23,755	24,070	24,660
Denominator	361,767	366,272	370,078	381,990	383,114
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

2. **Section Number:** Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

3. **Section Number:** Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

HEALTH STATUS INDICATOR MEASURE # 02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2002	2003	2004	2005	2006
Annual Indicator	1.3	1.4	1.4	1.4	1.4
Numerator	4,976	5,133	5,364	5,343	5,471
Denominator	372,369	377,374	381,441	394,148	392,830
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

2. **Section Number:** Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

3. **Section Number:** Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

HEALTH STATUS INDICATOR MEASURE # 02B

The percent of live singleton births weighing less than 1,500 grams.

	Annual Indicator Data				
	2002	2003	2004	2005	2006
Annual Indicator	1.0	1.1	1.1	1.1	1.1
Numerator	3,789	3,869	3,996	4,038	4,129
Denominator	361,767	366,272	370,078	381,990	383,114
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

2. **Section Number:** Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

3. **Section Number:** Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

Health Status Indicator Measure # 03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2002	2003	2004	2005	2006
Annual Indicator	10.3	10.2	10.0	9.7	9.4
Numerator	515	519	513	505	497
Denominator	4,999,699	5,095,345	5,144,013	5,223,840	5,284,398
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

3. **Section Number:** Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

HEALTH STATUS INDICATOR MEASURE # 03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	5.5	5.3	5.5	5.0	4.9
Numerator	275	272	281	261	258
Denominator	4,999,699	5,095,345	5,144,013	5,223,840	5,284,398
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #03B
Field Name: HSI03B
Row Name:
Column Name:
Year: 2006
Field Note:
Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

2. **Section Number:** Health Status Indicator #03B
Field Name: HSI03B
Row Name:
Column Name:
Year: 2005
Field Note:
Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

3. **Section Number:** Health Status Indicator #03B
Field Name: HSI03B
Row Name:
Column Name:
Year: 2004
Field Note:
Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth and death data.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

HEALTH STATUS INDICATOR MEASURE # 03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	33.6	30.9	27.8	31.2	31.2
Numerator	1,099	1,052	962	1,101	1,121
Denominator	3,272,868	3,401,692	3,464,173	3,532,418	3,590,332
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #03C
Field Name: HSI03C
Row Name:
Column Name:
Year: 2006
Field Note:
Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Health Status Indicator #03C
Field Name: HSI03C
Row Name:
Column Name:
Year: 2005
Field Note:
Data presents a projected linear trend based on vital statistics data from 1996 through 2003 (as of 7/16/07.)

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

3. **Section Number:** Health Status Indicator #03C
Field Name: HSI03C
Row Name:
Column Name:
Year: 2004
Field Note:
Source: DSHS Center for Health Statistics, Vital Statistics - data for this measure was entered in 2007 following the availability of the 2004 birth data.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

HEALTH STATUS INDICATOR MEASURE # 04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2002	2003	2004	2005	2006
Annual Indicator	226.7	182.3	174.2	234.7	240.8
Numerator	11,332	9,291	8,852	12,262	12,723
Denominator	4,999,699	5,095,345	5,082,759	5,223,840	5,284,398
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. ***(Explain data in a year note. See Guidance, Appendix IX.)***					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Numerator provided by the Texas EMS Trauma Registry.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Numerator provided by the Texas EMS Trauma Registry.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

3. **Section Number:** Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2004
   Field Note:

HEALTH STATUS INDICATOR MEASURE # 04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

	Annual Indicator Data				
	2002	2003	2004	2005	2006
Annual Indicator	35.4	74.2	63.9	54.8	53.5
Numerator	1,769	3,783	3,286	2,861	2,826
Denominator	4,999,699	5,095,345	5,144,013	5,223,840	5,284,398
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Numerator provided by the Texas EMS Trauma Registry.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Numerator provided by the Texas EMS Trauma Registry.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

HEALTH STATUS INDICATOR MEASURE # 04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	2002	2003	2004	2005	2006
Annual Indicator	113.5	224.4	220.8	209.2	175.4
Numerator	3,714	7,635	7,650	7,389	6,299
Denominator	3,272,868	3,401,692	3,464,173	3,532,418	3,590,332
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Numerator provided by the Texas EMS Trauma Registry.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Numerator provided by the Texas EMS Trauma Registry.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

HEALTH STATUS INDICATOR MEASURE # 05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	28.5	26.6	26.2	25.8	25.4
Numerator	22,835	21,948	21,977	22,025	22,073
Denominator	801,380	826,232	839,291	852,984	870,288
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Numerator provided by HIV/STD Epidemiology and Surveillance. Data for FY 2006 was estimated based on available data from the previous years.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Numerator provided by HIV/STD Epidemiology and Surveillance.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

HEALTH STATUS INDICATOR MEASURE # 05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Annual Indicator Data	2002	2003	2004	2005	2006
Annual Indicator	8.2	8.4	8.3	8.5	8.5
Numerator	32,949	33,099	33,834	35,012	36,190
Denominator	4,009,566	3,951,305	4,095,068	4,133,965	4,263,776
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2006
   Field Note:
   Numerator provided by HIV/STD Epidemiology and Surveillance. Data for FY 2006 was estimated based on available data from the previous years.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.dshs.state.tx.us).

2. **Section Number:** Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2005
   Field Note:
   Numerator provided by HIV/STD Epidemiology and Surveillance.

   Population data for Texas are provided by the the Texas State Data Center, Population Estimates and Projections Program (http://soupfin.tdh.state.tx.us).

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2006 Is this data from a State Projection? Yes Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	388,317	331,864	41,978	0	0	0	0	14,475
Children 1 through 4	1,495,250	1,276,135	164,455	0	0	0	0	54,660
Children 5 through 9	1,671,936	1,408,434	206,868	0	0	0	0	56,634
Children 10 through 14	1,728,895	1,440,483	227,924	0	0	0	0	60,488
Children 15 through 19	1,786,854	1,487,050	237,384	0	0	0	0	62,420
Children 20 through 24	1,803,478	1,516,133	222,386	0	0	0	0	64,959
Children 0 through 24	8,874,730	7,460,099	1,100,995	0	0	0	0	313,636

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	193,083	195,234	0
Children 1 through 4	772,792	722,458	0
Children 5 through 9	925,086	746,850	0
Children 10 through 14	981,603	747,292	0
Children 15 through 19	1,052,925	734,379	0
Children 20 through 24	1,041,267	762,211	0
Children 0 through 24	4,966,756	3,908,424	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2006 Is this data from a State Projection? Yes Is this data final or provisional? Final

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	998	762	231	1	1	0	0	3
Women 15 through 17	18,745	15,982	2,597	33	89	3	0	41
Women 18 through 19	34,041	28,806	4,880	70	199	13	0	73
Women 20 through 34	296,614	253,153	31,147	666	10,580	147	0	921
Women 35 or older	42,430	35,991	3,609	86	2,551	15	0	178
Women of all ages	392,828	334,694	42,464	856	13,420	178	0	1,216

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	371	627	0
Women 15 through 17	6,261	12,484	0
Women 18 through 19	14,164	19,877	0
Women 20 through 34	149,487	147,127	0
Women 35 or older	24,913	17,517	0
Women of all ages	195,196	197,632	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

For both parts A and B: Reporting Year: 2006 Is this data from a State Projection? Yes Is this data final or provisional? Provisional

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	2,437	1,843	530	5	44	1	0	14
Children 1 through 4	483	377	98	0	8	0	0	0
Children 5 through 9	280	208	60	1	11	0	0	0
Children 10 through 14	359	282	66	0	11	0	0	0
Children 15 through 19	1,133	973	146	1	13	0	0	0
Children 20 through 24	1,590	1,279	277	5	23	2	0	4
Children 0 through 24	6,282	4,962	1,177	12	110	3	0	18

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	1,361	1,076	0
Children 1 through 4	276	207	0
Children 5 through 9	183	97	0
Children 10 through 14	217	142	0
Children 15 through 19	704	429	0
Children 20 through 24	992	598	0
Children 0 through 24	3,733	2,549	0

Form 21
Health Status Indicators
Demographic Data
State: TX

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Provisional

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	7,071,252	5,943,966.0	878,609.0	0.0	0.0	0.0	0.0	248,677.0	2006
Percent in household headed by single parent	32.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2005
Percent in TANF (Grant) families	3.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2004
Number enrolled in Medicaid	2,043,570	1,623,946.0	363,831.0	6,404.0	24,190.0	0.0	0.0	25,199.0	2006
Number enrolled in SCHIP	521,085	248,115.0	28,348.0	1,078.0	10,789.0	0.0	0.0	232,755.0	2006
Number living in foster home care	34,275	23,973.0	9,592.0	86.0	117.0	0.0	0.0	507.0	2006
Number enrolled in food stamp program	1,565,649	1,164,935.0	368,183.0	4,647.0	18,589.0	0.0	0.0	9,295.0	2006
Number enrolled in WIC	1,954,075	1,749,574.0	144,873.0	12,060.0	13,259.0	1,165.0	26,469.0	6,675.0	2006
Rate (per 100,000) of juvenile crime arrests	1.8	1.4	0.4	0.0	0.0	0.0	0.0	0.0	2005
Percentage of high school drop-outs (grade 9 through 12)	1.3	1.3	1.7	1.6	0.5	0.0	0.0	0.0	2005

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	3,925,039.0	3,146,213.0	0.0	2006
Percent in household headed by single parent	0.0	0.0	32.0	2005
Percent in TANF (Grant) families	0.0	0.0	3.5	2004
Number enrolled in Medicaid	808,176.0	1,235,394.0	0.0	2006
Number enrolled in SCHIP	294,909.0	226,176.0	0.0	2006
Number living in foster home care	21,369.0	12,906.0	0.0	2006
Number enrolled in food stamp program	737,774.0	831,875.0	0.0	2006
Number enrolled in WIC	1,134,920.0	819,155.0	0.0	2006
Rate (per 100,000) of juvenile crime arrests	1.0	0.8	0.0	2005
Percentage of high school drop-outs (grade 9 through 12)	0.9	2.0	0.0	2005

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*
Reporting Year: 2006 Is this data from a State Projection? Yes Is this data final or provisional? Final

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	6,945,381
Living in urban areas	5,834,231
Living in rural areas	1,237,021
Living in frontier areas	63,798
Total - all children 0 through 19	7,135,050

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*
Reporting Year: 2006 Is this data from a State Projection? Yes Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	23,464,828.0
Percent Below: 50% of poverty	6.7
100% of poverty	15.4
200% of poverty	36.0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*
Reporting Year: 2006 Is this data from a State Projection? Yes Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	7,071,252.0
Percent Below: 50% of poverty	9.2
100% of poverty	20.8
200% of poverty	46.0

FORM NOTES FOR FORM 21

None

FIELD LEVEL NOTES

1. **Section Number:** Indicator 06A
Field Name: S06_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2008
Field Note:
Source: Epigram

2. **Section Number:** Indicator 06A
Field Name: S06_Race_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2008
Field Note:
Source: Epigram

3. **Section Number:** Indicator 06A
Field Name: S06_Race_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2008
Field Note:
Source: Epigram

4. **Section Number:** Indicator 06A
Field Name: S06_Race_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2008
Field Note:
Source: Epigram

5. **Section Number:** Indicator 06A
Field Name: S06_Race_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2008
Field Note:
Source: Epigram

6. **Section Number:** Indicator 06A
Field Name: S06_Race_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2008
Field Note:
Source: Epigram

7. **Section Number:** Indicator 06B
Field Name: S06_Ethnicity_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2008
Field Note:
Source: Epigram

8. **Section Number:** Indicator 06B
Field Name: S06_Ethnicity_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2008
Field Note:
Source: Epigram

9. **Section Number:** Indicator 06B
Field Name: S06_Ethnicity_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2008
Field Note:
Source: Epigram

10. **Section Number:** Indicator 06B
Field Name: S06_Ethnicity_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2008
Field Note:
Source: Epigram

11. **Section Number:** Indicator 06B
Field Name: S06_Ethnicity_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2008
Field Note:
Source: Epigram

12. **Section Number:** Indicator 06B
Field Name: S06_Ethnicity_Children20to24
Row Name: children 20 through 24

Column Name:
Year: 2008
Field Note:
Source: Epigram

13. **Section Number:** Indicator 07A
Field Name: Race_Women15
Row Name: Women < 15
Column Name:
Year: 2008
Field Note:
Source: Epigram

14. **Section Number:** Indicator 07A
Field Name: Race_Women15to17
Row Name: Women 15 through 17
Column Name:
Year: 2008
Field Note:
Source: Epigram

15. **Section Number:** Indicator 07A
Field Name: Race_Women18to19
Row Name: Women 18 through 19
Column Name:
Year: 2008
Field Note:
Source: Epigram

16. **Section Number:** Indicator 07A
Field Name: Race_Women20to34
Row Name: Women 20 through 34
Column Name:
Year: 2008
Field Note:
Source: Epigram

17. **Section Number:** Indicator 07A
Field Name: Race_Women35
Row Name: Women 35 or older
Column Name:
Year: 2008
Field Note:
Source: Epigram

18. **Section Number:** Indicator 07B
Field Name: Ethnicity_Women15
Row Name: Women < 15
Column Name:
Year: 2008
Field Note:
Source: Epigram

19. **Section Number:** Indicator 07B
Field Name: Ethnicity_Women15to17
Row Name: Women 15 through 17
Column Name:
Year: 2008
Field Note:
Source: Epigram

20. **Section Number:** Indicator 07B
Field Name: Ethnicity_Women18to19
Row Name: Women 18 through 19
Column Name:
Year: 2008
Field Note:
Source: Epigram

21. **Section Number:** Indicator 07B
Field Name: Ethnicity_Women20to34
Row Name: Women 20 through 34
Column Name:
Year: 2008
Field Note:
Source: Epigram

22. **Section Number:** Indicator 07B
Field Name: Ethnicity_Women35
Row Name: Women 35 or older
Column Name:
Year: 2008
Field Note:
Source: Epigram

23. **Section Number:** Indicator 08A
Field Name: S08_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

24. **Section Number:** Indicator 08A
Field Name: S08_Race_Children1to4
Row Name: children 1 through 4

Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

25. **Section Number:** Indicator 08A
Field Name: S08_Race_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

26. **Section Number:** Indicator 08A
Field Name: S08_Race_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

27. **Section Number:** Indicator 08A
Field Name: S08_Race_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

28. **Section Number:** Indicator 08A
Field Name: S08_Race_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

29. **Section Number:** Indicator 08B
Field Name: S08_Ethnicity_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

30. **Section Number:** Indicator 08B
Field Name: S08_Ethnicity_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

31. **Section Number:** Indicator 08B
Field Name: S08_Ethnicity_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

32. **Section Number:** Indicator 08B
Field Name: S08_Ethnicity_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

33. **Section Number:** Indicator 08B
Field Name: S08_Ethnicity_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

34. **Section Number:** Indicator 08B
Field Name: S08_Ethnicity_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2008
Field Note:
Estimated number based on data from Vital Statistics 1996 through 2003 (the latest available valid data).

35. **Section Number:** Indicator 09A
Field Name: HSIRace_Children
Row Name: All children 0 through 19
Column Name:
Year: 2008
Field Note:
Source: Epigram

36. **Section Number:** Indicator 09A
Field Name: HSIRace_SingleParentPercent
Row Name: Percent in household headed by single parent

Column Name:
Year: 2008
Field Note:
Source: http://www.aecf.org/cgi-bin/kc

37. **Section Number:** Indicator 09A
Field Name: HSIRace_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2008
Field Note:
Source: http:/www.aecf.org

38. **Section Number:** Indicator 09A
Field Name: HSIRace_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2008
Field Note:
Source: Texas Medicaid Program

39. **Section Number:** Indicator 09A
Field Name: HSIRace_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2008
Field Note:
Source: ACS - Monthly CHIP enrollment files, Demographic Analysis Unit, Strategic Decision Support, Tx HHSC, 2005-06

40. **Section Number:** Indicator 09A
Field Name: HSIRace_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2008
Field Note:
Source: Texas Food Stamp Client Profile, Strategic Decision Support, TxHHSC

41. **Section Number:** Indicator 09A
Field Name: HSIRace_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2008
Field Note:
Source: DSHS WIC database

42. **Section Number:** Indicator 09A
Field Name: HSIRace_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2008
Field Note:
Information provided by Lori Kirk, DPS staff.
Source: Lori Kirk, DPS, lori.kirk@dps.state.tx.us

43. **Section Number:** Indicator 09A
Field Name: HSIRace_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2008
Field Note:
Source: http:/www.tea.state.tx.us/research/pfds/dropcomp

44. **Section Number:** Indicator 09B
Field Name: HSIEthnicity_Children
Row Name: All children 0 through 19
Column Name:
Year: 2008
Field Note:
Source: Epigram

45. **Section Number:** Indicator 09B
Field Name: HSIEthnicity_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2008
Field Note:
Source: http://www.aecf.org/cgi-bin/kc

46. **Section Number:** Indicator 09B
Field Name: HSIEthnicity_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2008
Field Note:
Source: http:/www.aecf.org

47. **Section Number:** Indicator 09B
Field Name: HSIEthnicity_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2008
Field Note:
Source: Texas Medicaid Program

48. **Section Number:** Indicator 09B
Field Name: HSIEthnicity_SCHIPNo

Row Name: Number enrolled in SCHIP
Column Name:
Year: 2008
Field Note:
Source: ACS - Monthly CHIP enrollment files, Demographic Analysis Unit, Strategic Decision Support, Tx HHSC, 2005-06

49. **Section Number:** Indicator 09B
Field Name: HSIEthnicity_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2008
Field Note:
Source: Texas Food Stamp Client Profile, Strategic Decision Support, TxHHSC

50. **Section Number:** Indicator 09B
Field Name: HSIEthnicity_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2008
Field Note:
Information provided by Lori Kirk, DPS staff.
Source: Lori Kirk, DPS, lori.kirk@dps.state.tx.us

51. **Section Number:** Indicator 10
Field Name: Metropolitan
Row Name: Living in metropolitan areas
Column Name:
Year: 2008
Field Note:
Source: Census Data 2000

52. **Section Number:** Indicator 10
Field Name: Urban
Row Name: Living in urban areas
Column Name:
Year: 2008
Field Note:
Source: Census Data 2000

53. **Section Number:** Indicator 10
Field Name: Rural
Row Name: Living in rural areas
Column Name:
Year: 2008
Field Note:
Source: Census Data 2000

54. **Section Number:** Indicator 10
Field Name: Frontier
Row Name: Living in frontier areas
Column Name:
Year: 2008
Field Note:
Source: Epigram

55. **Section Number:** Indicator 11
Field Name: S11_total
Row Name: Total Population
Column Name:
Year: 2008
Field Note:
Source: Epigram

56. **Section Number:** Indicator 11
Field Name: S11_50percent
Row Name: Percent Below: 50% of poverty
Column Name:
Year: 2008
Field Note:
Source: Census Data 2000

57. **Section Number:** Indicator 11
Field Name: S11_100percent
Row Name: 100% of poverty
Column Name:
Year: 2008
Field Note:
Source: Census Data 2000

58. **Section Number:** Indicator 11
Field Name: S11_200percent
Row Name: 200% of poverty
Column Name:
Year: 2008
Field Note:
Source: Census Data 2000

59. **Section Number:** Indicator 12
Field Name: S12_Children
Row Name: Children 0 through 19 years old
Column Name:
Year: 2008
Field Note:
Source: Epigram

60. **Section Number:** Indicator 12

Field Name: S12_50percent
Row Name: Percent Below: 50% of poverty
Column Name:
Year: 2008
Field Note:
Source: Census Data 2000

61. **Section Number:** Indicator 12
Field Name: S12_100percent
Row Name: 100% of poverty
Column Name:
Year: 2008
Field Note:
Source: Census Data 2000

62. **Section Number:** Indicator 12
Field Name: S12_200percent
Row Name: 200% of poverty
Column Name:
Year: 2008
Field Note:
Source: Census Data 2000

63. **Section Number:** Indicator 09A
Field Name: HSIRace_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2008
Field Note:
http:/www.dfps.state.tx.us/Documents/about/data_book_and-Annual_reports/

Statistics from the previous year reflected the number of Children in foster care up to the end of August 2005.

64. **Section Number:** Indicator 09B
Field Name: HSIEthnicity_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2008
Field Note:
http:/www.dfps.state.tx.us/Documents/about/data_book_and-Annual_reports/