FY06
Texas Title V
Five -Year
Needs Assessment

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II. A. 1. Process for Conducting Needs Assessment

The process for conducting the needs assessment is described first for women and infants/children and adolescents and then for Children with Special Health Care Needs (CSHCN).

Process for Women, Infants, Children and Adolescents

The Title V Program is administered by the Texas Department of State Health Services (DSHS), which is one of the four health and human service agencies under oversight by the Texas Health and Human Services Commission (HHSC). In 2004, Title V staff initiated an extensive review of primary and secondary data for the Title V five-year needs assessment process by identifying multiple, relevant sources of health status and outcomes on MCH populations. In conjunction with the DSHS Research and Public Health Assessment (R&PHA) Office, MCH subject matter experts on perinatal health, child health, adolescent health and family violence were responsible for the selection and in-depth review of MCH population health status and system capacity indicators in preparation for comparison with stakeholder input to determine the state's priority needs. The subject matter experts were also responsible for integration of information from a multitude of state and national collaborative partnerships that are an ongoing source of key informant data.

Overview of the methodology

The five-year needs assessment methodology was designed to be consistent with the MCHB conceptual framework, *Overview for MCH Needs Assessment, Planning and Monitoring Process.* The steps in the methodology included the following:

- review and analysis of existing health status indicators, performance measures, outcomes, and systems capacity data to determine pertinent needs. Throughout the rest of the needs assessment document, these pertinent needs are called ***quantitative data needs***;
- collection of primary data through qualitative surveys of MCH stakeholders to determine ***qualitative data needs***;
- comparison of quantitative data needs to stakeholder qualitative data needs to determine ***critical needs***;
- stakeholder prioritization of critical needs to establish ***final priority needs***;
- synthesis of stakeholder input and subject matter expertise research to develop activities, output measures, and monitoring systems to measure progress;
- allocation of resources based on activity plans for FY06; and
- consultation with R&PHA to develop state performance measures and set national and state performance measure targets.

Details of the methodology

Quantitative data needs were deduced from MCH subject matter expert review of health status and systems capacity indicators. Types of data reviewed to determine actual need included trends of selected health indicators and outcomes data, such as rates of infant mortality, maternal mortality, teen pregnancy , and confirmed child abuse or neglect (Attachment A); available health capacity indicators; literature reviews; and recommendations from a variety of governmental reports and strategic plan documents related to MCH. Data were cross analyzed by available and relevant population

characteristics, such as age, race/ethnicitiy, socio-economic status, gender, and geographic setting in order to make meaningful deductions. Additionally, subject matter experts integrated information gleaned from ongoing consultations with collaborative partners and participation in MCH-related workgroups, advisory groups, and advocacy groups. These partnerships and groups have internal and external origins as well as state and national focus.

Key secondary data sources for the five-year needs assessment from DSHS included the following:

- Special Supplemental Nutrition Program for Women, Infants and Children (WIC);
- Newborn Hearing and Screening;
- Newborn Screening;
- Oral Health Program;
- Texas Health Steps (EPSDT in Texas);
- Center for Health Statistics;
- Texas Youth Behavioral Risk Survey; and
- Vital Statistics.

Non-DSHS sources included

- Health Resources & Services Administration, Maternal and Child Health Bureau;
- National Youth Behavioral Risk Survey;
- National Vital Statistics Report;
- University of Texas at San Antonio;
- Centers for Disease Control & Prevention - Behavioral Risk Factor Surveillance System and Morbidity and Mortality Weekly Report;
- National Center for Health Statistics;
- National Immunization Program, National Immunization Survey, Texas Youth Commission;
- Healthy People 2010, Health of Texans – 2002;
- Ross Mothers' Survey;
- U.S. Census Bureau;
- Texas Department of Family & Protective Services;
- Texas Education Agency;
- Department of Public Safety Uniform Crime Reporting; and
- Health & Human Services Commission – Texas Medicaid and the Texas Children's Health Insurance Program.

Data limitations mainly involved the lack of direct access to databases and the ability to link data files, such as birth certificate and WIC or linkage of mother and infant in hospital discharge files. For some of the databases, legal or Institutional Review Board approval is required to access and/or link data. Also, up to a two-year lag time occurs in closure of some databases, including statistics such as all vital records data and hospital discharge surveys. Some surveys were limited in scope, such as the Texas Youth Risk Behavior Survey, which was conducted only on public high school students in metropolitan areas and cannot be generalized to non-metropolitan areas or used for regional estimates. Additionally, complete demographics for cross analysis are not always available, especially

in national data sets. Finally, data collection systems do not always align with the required national performance measures. An example is that National Performance Measure #9 relies on the percentage of the total population of 3rd grade children who receive dental sealants, but Texas data is based on a smaller population of 3rd graders who receive free and reduced lunches.

Stakeholder input, or ***qualitative data need,*** was derived from the results of a survey designed to collect qualitative data. To collect the data, MCH stakeholders were identified through a collaborative process to ensure inclusion of the full array of persons interested in MCH issues. Internal and external partners were polled to expand existing distribution lists, and the final list included approximately five hundred stakeholders. The diverse group included but was not limited to contractors and providers of health services to MCH populations, professional associations, advocacy groups, state agencies and local government agencies, hospital districts, judges for child protective services and a multitude of regional advisory groups. The following is a summarized list of the types of stakeholders:

Contractors/Providers of Health Care and/or Health Services

- Abstinence Education
- Adolescent healthcare providers
- Breast/cervical cancer providers
- Mental health and mental retardation (MHMR) providers
- Service Delivery Integration contractors (a DSHS initiative)
- Federally Qualified Health Centers (FQHC)
- Primary health care Title V contractors
- Contractors associated with genetics
- WIC agencies
- Local public health departments
- County indigent care program participants
- Newborn Hearing Screening providers
- Program for Amplification for Children of Texas contractors
- MHMR State School administrators
- Substance Abuse providers

General MCH Stakeholders

- Professional associations, such as the Texas Medical Association and the Texas Nurses Association
- Early Childhood Intervention Program
- Hospital districts
- Violence prevention workgroups
- Judges for child protective service cases
- Mental Health Planning and Advisory Council
- DSHS State Health Strategic Partnership
- Oral Health Summit participants
- Perinatal Depression Partnership
- Perinatal Systems distribution list
- Regional MCH personnel
- FQHC Incubator Program awardees
- Safe Riders Program
- School Health Centers
- TX School Health Network

- TX Program Services Committee
- TX Safe Kids Coalition
- TX Healthy Start Alliance
- Transportation Specialists (Texas Department of Transportation)

A letter of explanation and a three-part survey for primary data collection (Attachment B) were sent to approximately 500 stakeholders on November 1, 2004, with the following instructions:

- Part I was to collect demographic information on stakeholders.
- Part II was designed to seek stakeholder input, or ***qualitative data need***, on potential priority needs, concerns or areas for improvement, the rationales, and one or two activities to address each need for up to three topic areas. Part II was divided into the following:
    - Part II-a was for the MCH population of women (over 22 years) and infants (0-11 months).
    - Part II-b was for the MCH population of children and adolescents (1-21 years).
- Part III was to suggest activities and/or best practices to address the national performance measures.

The purpose of the survey was to establish the ***qualitative data needs*** for MCH populations from the stakeholder perspective to aid in the identification of critical needs for the state. Stakeholders were informed that a separate process would be conducted for assessment of CSHCN needs (described later in this section under the subheading "Process for CSHCN Population").

To complete data collection for Part II and Part III of the survey, reminders were sent out twice to remind stakeholders of the deadline and purpose for response. Final stakeholder response was approximately 20% (91 responses). Title V MCH subject matter experts analyzed the qualitative data extensively to assure that all stakeholder input was retained and categorized for future reference in the selection of priority needs and the development of activity plans. Input from Part II of the survey (need, concern, or area of improvement and suggested activities) was categorized by MCH service levels (Attachment C) and was considered for the development of activities to address state priority need. Suggested activities for the national performance measures from Part III were also analyzed for each MCH population for feasibility of implementation (Attachment D) and were considered in the development of national activity plans. A summary of the analyses of Attachments C and D appears in section II.B.3., Assessment of Needs of the MCH Population.

The comparison of the two sets of data, ***quantitative*** and ***qualitative data needs***, and the consideration of control, influence or feasibility of systems capacity resulted in a list of ***critical needs*** with associated rationales that was sent out on April 29, 2005 for final prioritization by stakeholders. The packet was sent to the original 91 stakeholders who responded to the first survey in November, 2004, DSHS regional staff, and DSHS staff with key responsibilities relating to MCH, with a goal of selecting the state's priority needs for FY06. A total of 80 stakeholders (48.7%) responded. Of the total, 45% (36) were the original external stakeholders, 32.5% (26) were DSHS regional staff, and 22.5% (18) were

DSHS central office staff. Results of the critical needs and the stakeholder prioritization are discussed in detail in Section II. B.5., Selection of Priority Needs.

In the final prioritization phase, the highest ranked critical needs from the stakeholder prioritization were examined for alignment with national performance measures (NPM) and will be addressed through the NPM activity plans. The highest ranked critical needs for women/infants and children/adolescents which did not align with national performance measures are the final state priorities and will be addressed through state activity plans.

Activity plans for the NPMs and the final state priorities were developed from the synthesis of stakeholder input, the consideration of the MCH resources capacity, and subject matter expert literature review of best practices and other states' experience. Stakeholder input from Part II-a and Part II-b of the survey was considered in the development of state activity plans. Stakeholder input from Part III of the survey was considered in the development of national activity plans.

Adequate and appropriate resources will be allocated for the implementation of activity plans by DSHS Central Office, DSHS Regional Offices, and local providers selected through a competitive request for proposal (RFP) process. In order to monitor progress on the annual plan, all entities receiving Title V funds are subject to a contract monitoring system that is tied to output measures and state and national performance measures in the annual plan. Providers of service who do not have a direct contract reporting responsibility to the Title V program but have associated activities to support either state or national performance measures are routinely involved in collaborative relationships with the MCH subject matter experts. This collaborative mechanism facilitates a two-way exchange of information between the MCH subject matter experts and the implementers of the Title V activities. In addition to facilitating receipt of quarterly progress reports on Title V activity plans, the MCH subject matter experts provide periodic feedback on progress to all programs that implement state and national activities.

Process for Children with Special Health Care Needs

The CSHCN Services Program within the DSHS conducted a multi-tiered needs assessment during the summer and fall of 2004 as part of the overall Title V five-year needs assessment. Staff gathered and analyzed primary and secondary health status data from national and state sources, and researched indicators related to the health and well being of children and youth with special health care needs in Texas.

Data sources within DSHS included the DSHS Center for Health Statistics, CSHCN Services Program data (including survey data gathered over the last several years), and DSHS contractors of CSHCN services. Non-DSHS sources included the following:

- Texas Health and Human Services Commission (HHSC);
- Department of Assistive and Rehabilitative Services (DARS);
- Department of Family and Protective Services (DFPS);
- Department of Aging and Disability Services (DADS);
- Texas Education Agency (TEA);
- Texas Council on Developmental Disabilities (TCDD);
- University of Texas Center for Disability Studies;
- Texas A&M Center for Housing and Urban Development;

- Texas State Data Center;
- Texas Pediatric Society;
- Regional Advisory Subcommittees on CSHCN; and
- Governor's Committee on People with Disabilities.

Other sources included the following:
- National Survey of Children with Special Health Care Needs;
- National Longitudinal Transition Study;
- Social Security Administration;
- U.S. Census Bureau;
- KIDS Count 2004; and
- Kaiser Foundation.

Staff also gathered information and reviewed recommendations from legislative and other reports developed by key statewide advisory councils/groups and collaborative initiatives in which DSHS has a partnership role. The latter included the Children's Policy Council, Texas Integrated Funding Initiative, Promoting Independence Initiative, the Texas Council for Developmental Disabilities, and the DSHS Medical Home Workgroup. DSHS CSHCN Services Program staff worked to increase awareness of the Title V CSHCN performance measures among these and other key stakeholder groups as they identified and considered the needs of CSHCN in Texas and formulated recommendations for service system improvement. Thus, these groups and their associated needs assessment input and recommendations served as independent focus group forums and became resources for valuable Title V needs assessment data. Many of these groups issued formal reports (some reports submitted to the Texas Legislature). Due to increased awareness of the Title V performance measures, some of these groups specifically mentioned the Title V performance measures in their reports and addressed the measures in their recommendations.

Additional information for the needs assessment process was collected through surveys and focus forums conducted by the Texas Center for Disability Studies in the fall of 2004. The Texas Center for Disability Studies surveyed professionals regarding issues related to early care and education and health care for young children. Focus forums were held in ten locations across the state with over 100 parents of young children. Nearly 30% of the focus forum participants were parents of young children with disabilities.

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Following the background data collection, DSHS staff (central and regional) who work closely with CSHCN and their families reviewed the data and identified areas of need and key issues. Next, broad-based stakeholder input was sought from families of CSHCN (families served by the CSHCN Services Program, parents identified by Texas Parent to Parent, the CSHCN SP contractors and Regional case managers, etc.), adults with special health care needs (e.g. the Texas Council for Developmental Disabilities), advocacy groups (e.g. Advocacy, Inc., the Disability Policy Consortium, United Cerebral Palsy, the Texas Center for Disabilities Studies, etc.), health care providers (e.g. the Texas Pediatric Society, the Texas Medical Association, the Children's Hospital Association of Texas, the Texas Academy of Family Physicians, managed care organizations, other health provider

organizations, etc.), providers of other community services and supports for CSHCN, academicians, policy makers, state agencies, state or local interagency groups, and others who had expressed an interest in CSHCN. In all the CSHCN SP distributed surveys to 347 stakeholders to identify priority needs and generate recommendations for addressing those needs. All stakeholders were encouraged to distribute the survey tool to others concerned about children with special health care needs and to encourage their response. Individuals and organizations in this broad stakeholder group provided input on a summary of initial data findings and key issues, identified additional issues, and provided recommendations regarding prioritization of activities to improve services and supports for CSHCN and their families in Texas. Stakeholder input was received from 39 respondents representing every region in Texas. Parents of children with special health care needs, adults with special health care needs, and advocacy groups represented about 15% of the stakeholder responses. Hospitals, health care facilities, and other health care providers represented an additional 29% of responses of the stakeholder responses. Community-based organizations, DSHS contractors (including advisory committees), and other affiliations each represented about 16% of responses. Stakeholder input from other state agencies represented about 8% of responses.

Survey respondents provided more than 500 suggestions for addressing the needs of CSHCN and their families. Eighty-four suggestions addressed increasing family participation in decision-making and family satisfaction with the services they receive. Examples include: “re-establish state level advisory committee for children and youth with special health care needs;” and “investigate where the gaps are [in family involvement] and attempt to develop family partners for this process.

Eighty-nine suggestions addressed the expanding medical homes for CSHCN. Examples include: “train on the medical home and on specifics of how it is to be provided in Medicaid and CHIP, to agency staff, providers, families;” and “provide state support to pediatricians to facilitate the implementation of medical homes.”

Eighty-one suggestions addressed the health insurance issue. Examples include: “restore CHIP benefits that were reduced by the previous legislature;” and “reassess eligibility criteria and cover the large number of families without any health insurance for their children.”

Ninety-one comments were addressed to improving the community systems to make them easier to use. Examples include: “assure there are adequate providers for all cultural and ethnic groups;” and “conduct survey of doctors and other health care providers to document the reasons for their non-participation in Medicaid, CHIP or CSHCN SP health care benefits. Use this information to develop recommendations to increase capacity. Any effort in this area should be coordinated with HHSC and DADS.”

Ninety suggestions were targeted at improving transition services for youth with special health care needs preparing to enter adulthood. Examples include: “develop a train the trainer model in which staff train parents on transition issues and they train other parents;” and “provide case management for foster youth with special healthcare needs who are entering adulthood.”

Sixty-eight suggestions were made regarding keeping children in families in their communities. Examples include: "Must also address "front-door" issues and look at how to limit the number of children going into institutions;" and "increase awareness and funding for family support services."

DSHS used the results of the five-year needs assessment to develop the CSHCN Services Program annual plan. As part of the broad stakeholder assessment, respondents provided information about current activities and their willingness to participate in collaborative workgroups, listservs, or other efforts to assist in addressing specific issues and concerns. This information will assist the CSHCN Services Program in establishing effective and ongoing partnerships with stakeholders, including families with children with special health care needs, throughout Texas.

Collaborative Processes for Women, Infants, Children, and Adolescents

Input from collaborative partnerships and workgroups is a key component in the needs assessment process and the final selection of the state's priority needs. Participants in these collaboratives represent a broad base of programs and initiatives related to MCH populations. These participants serve as ongoing key informants to MCH subject matter experts, who analyze stakeholder input and other multiple sources of data to determine priority needs and develop annual plans. In turn, the MCH subject matter experts provide quarterly feedback to many stakeholders and partners on the progress of the activity plans. Ongoing feedback about the Title V program activities also occurs through meetings and various forums that MCH subject matter experts attend on a regular basis. Some examples of these meetings are the Teen Pregnancy Workgroup, the March of Dimes, the Adolescent Mental Health Initiative Workgroup, and the HHSC Office of Early Childhood interactions. This mechanism of providing and receiving information is a strength for the Texas Title V program that assures connections with all relevant programs in the state to achieve the highest possible level of awareness of current MCH needs and best practices.

Another principal source of data inputs in between five-year needs assessments is an ongoing review by the MCH subject matter experts of updates in the primary health status indicators used for MCH populations, review of applicable secondary data sources, and an ongoing literature review for best practices and evidence-based interventions. The MCH subject matter experts are assigned to populations and specific issue areas in order to build and retain subject matter expertise. These staff also participate actively in the collaborative processes described above and thus are able to continually integrate stakeholder input into the Title V grant development process.

Collaborations and partnership building for CSHCN are discussed in Section II.B.2., Needs Assessment Partnership Building and Collaboration.

Strengths and Limitations of Current Methods and Procedures

Women, Infants, Children and Adolescents

The current five-year MCH need assessment process benefited from the generation of an extensive amount of data from stakeholder input and MCH subject matter expert review. The qualitative survey data derived from a broad group of stakeholders (***qualitative data***

needs) was then compared to the review of quantitative health status data and qualitative data from literature reviews (***quantitative needs***) by MCH subject matter experts. The MCH stakeholder process involved use of a survey to collect primary data in the fall of 2004 and a second round of stakeholder input into the selection of priority needs in the spring of 2005. Although both types of data, stakeholder input and subject matter expert review, are valuable to the Texas Title V Program, the strength is that each set validated and complemented the other set. The MCH subject matter experts utilized this complete picture of the MCH populations' health status and capacity of MCH systems development to identify the priority needs and develop activity plans.

A limitation of the MCH stakeholder input process is the receipt of input for which the Title V program has no authority, control or influence, or there may be a lack of resources to address. Some examples of this type of input are to require schools to provide comprehensive sex education, to increase Medicaid reimbursement rates, to teach public health nurses and school nurses to apply dental sealants, to enhance the Children's Health Insurance Program (CHIP) funding and covered services, and to allow more money for CHIP program to cover more children.

A strength for the Title V Program is that all MCH subject matter experts are within the same office. Their interactions with each other more fully strengthen the Title V needs assessment process.

A limitation and an opportunity to be explored is that MCH stakeholder primary data collection has been limited to the five-year needs assessments. In 2005 and beyond, Title V staff will explore opportunities for further nurturing the stakeholder input process on an ongoing basis and establish additional mechanisms for primary data collection, such as conducting periodic focus groups and or surveys. Engagement of stakeholders throughout the year may assure a higher response rate on surveys and other data collection methods. One potential mechanism to expand involvement with stakeholders may be to add a stakeholder link to the DSHS Title V webpage that relays up-to-date information on best practice models from other stakeholders and provides a limited technical assistance question and answer section.

<u>Children with Special Health Care Needs</u>

Regarding strengths and limitations for CSHCN, state-level data regarding children with special health care needs and their families is becoming more available, however, information may be based on indicators related to differing definitions of special health care needs and/or disability. The National Survey of Children with Special Health Care Needs (2001) provided the first state-level data regarding the prevalence of chronic health conditions and disabilities and other data related to performance measures for children with special health care needs and their families in Texas. Continuation of such data collection will be essential to enable states to measure progress over time.

In addition to the direct stakeholder survey input, the CSHCN Services Program has benefited from the independent needs assessment processes and recommendations of several existing key stakeholder groups (e.g. the Children's Policy Council, the Promoting Independence Advisory Council, the Texas Council on Developmental Disabilities, etc.). The formal assessments and reports from these groups have greatly enriched and

strengthened the content and validity of the Title V CSHCN Five-Year Needs Assessment process.

II. B 2. Needs Assessment Partnership Building And Collaboration

Title V MCH subject matter experts participate on a national, state and local level in building collaborations and enhancing partnerships with other agencies, organizations and programs focusing on MCH populations, including CSHCN, to provide and receive information. The exchange of information that occurs throughout the year between DSHS MCH experts and many collaborative partners is integrated into discussions of MCH population status and promotion of best practices throughout the year and into the selection of priority needs and development of activity plans in the Title V needs assessment process. Participation in all these activities also allows the MCH experts to fully participate in promoting progress toward the agency priorities which focus on the health of all Texans (immunizations, fitness and nutrition, and health disparities) and to assist in the implementation of strategies to achieve the goals in the Texas State Strategic Health Partnership. This partnership includes a wide range of stakeholders who collaborate to strategically plan for broad health-related issues in Texas, such as obesity prevention.

Collaborations for women and infants

On the national level, the Title V Perinatal Coordinator has a strong working relationship with the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau and the federal Office of Women's Health. Also, the Perinatal Coordinator participates in activities facilitated by the Association of Maternal and Child Health programs (AMCHP) to advocate for quality healthcare for women, children and families, especially those who are underserved or have low incomes. The Perinatal Coordinator routinely participates in AMCHP conference calls, webcasts, planning sessions and other networking opportunities, as well as presented at AMCHP Action Learning Labs, developed and presented sessions for annual conferences and assisted with prioritizing activities and planning events. All of these activities have a focus on improving women's and perinatal health. As a result of these interactions, the Perinatal Coordinator serves on the federal Region VI Office on Women's Health (OWH) Alliance team which meets periodically to develop and implement coordinated women's health activities throughout the state, region and the country.

Within Texas, a major external national partner is the March of Dimes (MOD), which works with states on improving perinatal outcomes and reducing prematurity and funds many projects accordingly. Another important collaborative partner is the Texas Healthy Start Alliance, which funds six Healthy Start projects in Texas to focus on the reduction of infant mortality, low birth weight and racial disparities in perinatal outcomes. Other collaborations include the Texas Medical Association, the Texas Pediatric Society and Central Texas Healthy Mothers, Healthy Babies Coalition. Title V staff serve on committees or have established working relationships with all of these organizations. Members of these organizations are included in DSHS workgroups and planning committees and also serve as a means of providing consumer input and feedback, which the Title V MCH Perinatal Coordinator integrated into the five-year needs assessment process.

Within the Texas Health and Human Services Commission umbrella, collaborations have been forged both within DSHS and with other HHSC agencies. These include the Teen

Pregnancy Prevention Workgroup, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), programs for mental health and substance abuse prevention, the Nutrition and Physical Activity Workgroup (for obesity prevention), the HIV/STD Prevention Program, the Office of Tobacco Prevention, and the Interagency Policy Team, a multi-agency workgroup that concentrated on developing a comprehensive, integrated approach to screening clients for mental health problems, substance abuse and domestic violence.

These partnerships have been built through different methods, including participation on workgroups and committees, coordinating grant applications and planning conferences and events, information exchange on a routine basis, developing and implementing joint activities and working together on state and national initiatives such as The March of Dimes Prematurity Campaign or National Women's Health Week. Within DSHS, Title V staff initiated the formation of an informal group, the Women's Health Network, which convened to learn more about the role each representative program plays in promoting women's health and to address women's health issues in a systematic, comprehensive manner. The goal of these partnerships and collaborations is to have a thorough understanding of the mission, objectives and operational approach of each program in order to gauge mutual benefit in joining together on an activity or when and how to effectively network between partners.

Key benefits resulting from collaborative efforts are the networking forums, the leveraging of resources and strengths, the promotion of best practice and evidence-based interventions, and the integration of shared information into the needs assessment process. Forums for networking facilitate understanding the systems and resources that exist to meet client needs or to improve outcomes within a population. Collaborations also create opportunities to leverage resources in order to work more effectively and efficiently. For example, working with other programs and partners provides a broader understanding of what services are available, where services are located, and what gaps in service exist in the pyramid levels of service. This applies to the assessment of direct services as well as enabling services, such as transportation or translation. Collaboration also enables the various partners to bring different strengths to a project. For example, in developing a population-based approach to breastfeeding or immunizations, collaborating programs can capitalize on existing infrastructure, activities and materials and then design and promote strategies and activities to fill in the identified gaps

Collaborations for children & adolescents

On the national level, the Title V Adolescent Health Coordinator works with the National Network of State Adolescent Health Coordinators, which is the national advocacy agency for adolescent health, the Association of Maternal Child Health Programs, the National Adolescent Health Information Centers, the Konopka Institute of Best Practices, and HRSA MCHB for adolescent health issues. Along with other partners, the Adolescent Health Coordinator participated in a number of activities to increase the capacity of state health programs, including the creation of a concept paper on the common vision, guiding principles and theoretical framework of adolescent health and development; the implementation of a policy agenda to strengthen the state and territorial capacity to address adolescent health through strong adolescent health initiatives and programs; a strengthening of relationships between State MCH Directors and State Adolescent Health Coordinators;

and the development and implementation of feasible recommendations from the report, *System Capacity for Adolescent Health: A Public Health Improvement Tool.* The adolescent health coordinator also serves in an advisory role for the Children's Safety Network Committee in order to stay abreast of children's safety related issues such as suicide prevention, traffic safety and injury prevention. Participation in this group increases awareness of other states' best practices and enhances the injury prevention activities benefiting children ages zero to 21.

Additionally, the Adolescent Health Coordinator works collaboratively with the Alliance Against Underage Drinking to reduce the number of under age drinkers in Texas. The coordinator also worked with the Texas Suicide Prevention Community Network to develop a toolkit for communities to create, support, and empower suicide prevention coalitions across the state. Due to documented need for adolescent mental health services, DSHS has taken a lead in 2005 in establishing the Adolescent Mental Health in Primary Care Initiative Workgroup to focus on mental health screening in primary care settings. The Adolescent Health Coordinator participates actively in this group, which is led by the DSHS Assistant Commissioner for Behavioral and Community Health Services. Members of the workgroup initiative are designing a pilot project to be implemented in 2006. If successful, the project could become a national model.

Through participation with the HRSA Healthy Child Care America Grant, a partnership formed between the National Training Institute in North Carolina, DSHS, and HHSC. From this partnership, a state level task force consisting of local stakeholders was formed in order to develop a network of physician medical consultants and child care health consultants who work to improve the health and safety of the many children who participate in out-of-home child care. The Title V Early Childhood Coordinator participates actively in these activities to advocate for medical homes and quality healthcare for all children. The Early Childhood Coordinator also plays a central role in providing leadership for planning and implementation in the development of a statewide early childhood comprehensive systems (SECCS) plan, which is gearing for implementation in 2006. This participation has facilitated positive partnerships and collaborations between DSHS and local early childhood agencies and advocates throughout the state, and the Title V Early Childhood Coordinator is actively involved in connecting the activities between the SECCS grant and the Title V state activities for FY06. Additionally, both the Early Childhood Coordinator and the Adolescent Health Coordinator participate in the Texas Immunization Stakeholder Working Group, which was formed through a recommendation of the 78th Texas Legislature in 2003 and comprises a wide variety of internal and external stakeholders. Participants include DSHS staff, other state agencies such as the Texas Education Agency, representatives from physician, nurse and pharmaceutical professional associations, and the HHSC Office of Early Childhood Coordination. The purpose is to increase partnerships across the state to raise vaccine coverage levels and improve immunization practices for all Texans. The exchange of information from these partnerships is beneficial to the Title V program in determining critical needs related to immunizations and developing activity plans to address those needs.

Title V staff also coordinate and provide leadership for the Teen Pregnancy Prevention Workgroup (TPPW), comprising of employee stakeholders from DSHS and other state agencies. The purpose of the workgroup is to build state agency capacity that will in turn promote enhancement of statewide local infrastructure to coordinate statewide efforts for

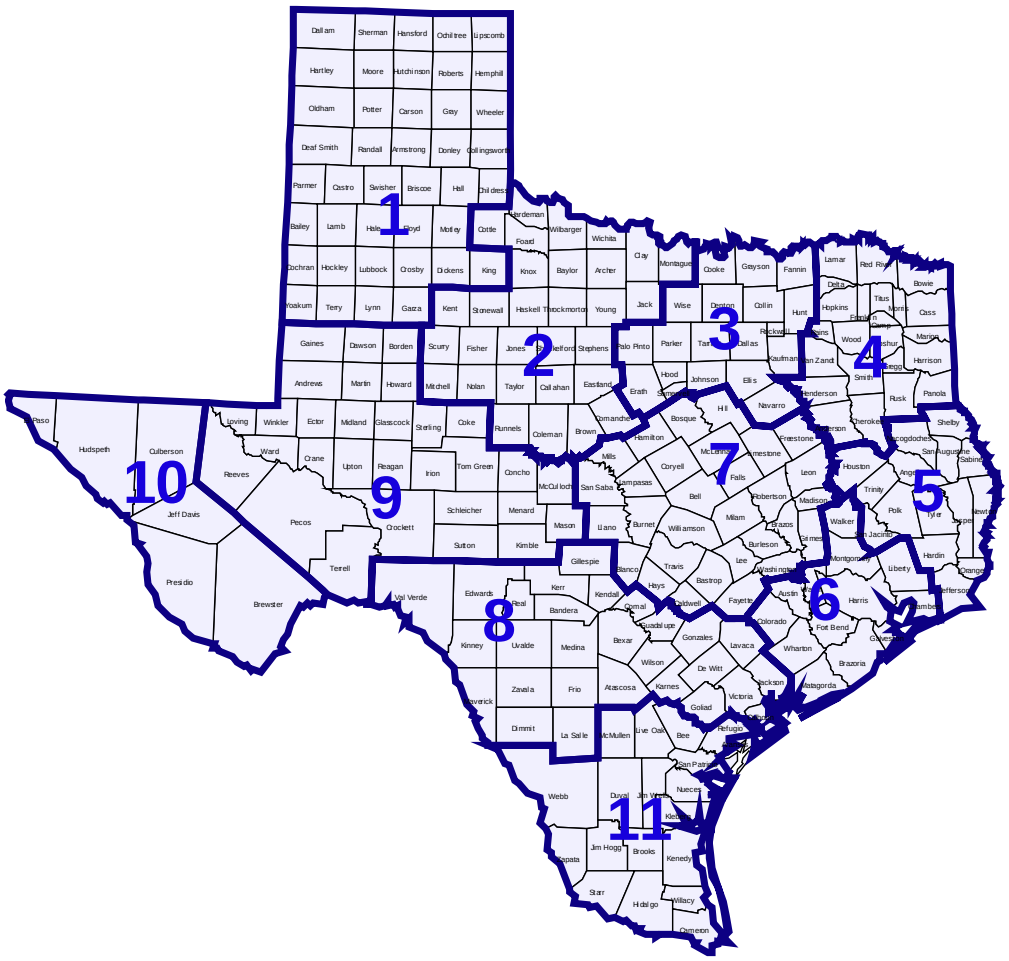
teen pregnancy prevention. The TPPW consists of individuals from DSHS programs that promote adolescent health, abstinence education, pregnancy prevention, STD prevention, and women and children's physical and behavioral health. TPPW also includes representatives from the Office of the Attorney General and the Center for Health Training, a capacity-building community based organization in Austin, Texas. Participation in these activities leads to the identification of best practices and the integration of relevant and up-to-date information on adolescent health into the final selection of priority needs and the subsequent development of activities to address adolescent health. Title V staff also continue to provide leadership in the planning and implementation of the Strategic Plan to Prevent Violence Against Women in Texas through participation in the Interpersonal Violence Prevention Collaborative. The plan recommends the development and maintenance of comprehensive health services systems, including development and maintenance of health services standards/guidelines, training, data and planning systems. Implementation has begun and involves several state agencies, statewide and local organizations and advocacy groups related to reducing violence against women.

Collaborations for CSHCN

As is evident in the details provided in Section II. B.1, the needs assessment process involved multiple data sources and extensive stakeholder involvement and partnerships. The CSHCN Services Program staff continue their active participation in the meetings and activities of key state-level stakeholders, including the Children's Policy Council; Promoting Independence Advisory Council; Texas Parent to Parent Advisory Committee; Texas Council on Developmental Disabilities; Early Childhood Intervention Advisory Council; Texas Integrated Funding Initiative; Community Resource Coordinating Groups State Council; Texas Pediatric Society; Medical Home Workgroup; Traumatic Brain Injury Advisory Council; Leadership and Education in Adolescent Health Advisory Committee; Autism Advisory Council; and the Texas Center for Disability Studies, whose members convene to improve the service systems impacting CSHCN in Texas. These state-level partners as well as numerous community-based stakeholders contributed to the Title V CSHCN five-year needs assessment and will continue to inform and monitor progress in meeting the prioritized areas need. As indicated in the section above, as part of the needs assessment process, stakeholders (at the local and state levels) indicated their willingness/interest in working with the DSHS CSHCN Services Program on specific activities to address needs of CSHCN and their families. Thus, partnerships have been strengthened and the groundwork is laid for ongoing collaboration, both specific to certain activities and general to address statewide broader service system issues.

II.B.3. Assessment of the Needs of the MCH Population

The following map will serve as a reference for the narrative in Section II.B.3, Assessment of the Needs of the MCH Population.



In order to complete a thorough assessment of the MCH population, the Title V program assessed and compared the ***quantitative*** and ***qualitative data needs*** for women and infants and for children and adolescents. To determine ***quantitative needs***, Title V MCH subject matter experts reviewed extensive health and capacity data (Attachment A) and performed a thorough literature review to determine state-of the-art evidence-based interventions and review other states' experiences. To determine the ***qualitative data needs,*** Title V staff developed and distributed a survey to a group of several hundred stakeholders across the state. Attachment B contains the cover letter and survey. Stakeholders were asked to specify needs and associated activities for up to three topic areas for women and children and/or children and adolescents. Attachment C is an analysis of stakeholder input on state needs and activities. Stakeholders were also asked to suggest activities for the NPMs as part of the survey process. Attachment D is an analysis of the suggested NPM activities. The remainder of this section contains a discussion of the finding from the assessments.

Women and Infants

Assessment of *actual needs*

The following assessment of ***quantitative data needs*** was performed by Title V MCH subject matter experts after an extensive review of health and capacity data.

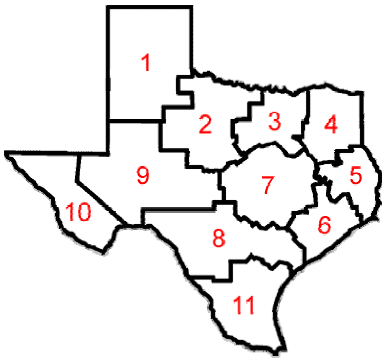
Population: With an area of 261,979 square miles divided into 254 counties, Texas has counties that are larger in area than some states. The state is divided geographically into 11 health service regions (HSRs), with regional offices managed by physicians. In 2000, the population of Texas was 21 million. Projections show that by the year 2010, the total population is expected to be 24 million. Slightly more than half of the Texas population (10.5 million) is women. Almost one third of the Texas population (6.4 million) is between the ages of 18 and 64. Of this 6.4 million, about 2.4 million are low-income women, the predominant target population of the Texas Title V Program. In 2003, there were 377,374 live births in Texas, 51% of which were Medicaid deliveries.

Births in Texas, 2003

White	*138,464*	*36.7%*
African American	*41,700*	*11.1%*
Hispanic	*182,528*	*48.4%*
Other	*14,682*	*3.9%*
Total	***377,374***	***100.1%****

*Source: DSHS Vital Statistics *Does not total 100% due to rounding.*

DSHS Health Service Regions



Delivering healthcare services in Texas can be difficult, in part due to the lack of providers and the high number of counties deemed "rural." In January 2002, the United States Department of Agriculture (USDA) classified 21% (53) of Texas counties as urban and the remaining 79% (201) as either rural or frontier. Approximately, 15% of the Texas population lives in non-metro counties. Many Texas counties have been designated by the federal Department of Health and Human Services (DHHS) as whole or partial county Medically Underserved Areas (MUAs) or as eight medically underserved populations (MUPs). The majority of the counties along the Texas –Mexico border (HSRs 8, 9, 10 and 11) are designated as Health Professional Shortage Areas (HPSAs).

2004 Texas County Health Service Designations

Whole county Medically Underserved Areas (MUAs)	176 counties
Partial county MUAs	88 (in 48 counties)
Federal Medically Underserved Populations (MUPs)	8
Exceptional MUPs - governor designation	6
Border-region MUAs	46 MUA designations in 43 border counties
Whole county Health Professional Shortage Area (HPSA) designations (Primary Care)	123
Whole county Health Professional Shortage Area (HPSA) designations (Mental Health)	189
Whole County HPSA population	3,101,526
Partial county HPSA designations (Primary Care)	47 (in 16 counties)
Border-region Health Professional Shortage Area (HPSA) designations	47 HPSA designations in 39 counties (4 border counties have no HPSA designation)
Total Texas counties	254

Source: TDH Health Professional Resource Center, 2004

Consequently, in some parts of the state, women are faced with either traveling great distances to receive primary health care services, including maternal and child health and mental health, or not having access to services.

Diversity: Texas also differs from most states in the diversity and the continuous growth of the population. Census figures for 2000 show that there were 11 million non-Hispanic Whites, 2.4 million African Americans, 6.7 million Hispanics, and 700,000 "Others," including Asians. Projections for 2010 estimate that the number of Texas residents will grow by a total of 16%, resulting in projections of 11.5 million Non-Hispanic Whites, 2.7 million African Americans, nine million Hispanics, and one million "Others." Within the next decade, more than 50% of the Texas population will comprise of members of an ethnic or minority group. Population projections for 2003 for women between the ages of 10-44 indicate that of the 5,672,988 women in Texas; 2,655,528 were White; 725,389 were African American; 2,075,448 were Hispanic; and 216,890 were classified as "other."

Within these broad racial categories, numerous ethnicities and cultures are represented, including Vietnamese, Mennonite, Native American, and those from Mexico and most countries in Central and South America. This mix yields many rich cultures and traditions that can result in cultural and linguistic barriers for women seeking health care as well as for providers of services.

Poverty: U.S. Census data reveal that in 1999, an estimated three million people in Texas lived in families with incomes below the federal poverty level (FPL) guidelines. The 2000 poverty rate in Texas was 15.6% overall, the seventh highest in the nation. The national rate was 12%. Along the Texas-Mexico border, the poverty rate is even higher. In HSR 11 along the United States-Mexico border, the poverty rates in Starr and Zavala Counties were 51% and 42% respectively. Within ethnic categories, the poverty rate in Texas was 25.4% for Hispanics, 23.4% for African Americans and 7.8% percent for Non-Hispanic Whites. More women (16%) lived in poverty than men (13.5%). Also, 30% of individuals living in female-heads of households lived in poverty. In 2002, approximately 22% of women were at risk of not being able to see a health care provider due to cost. In 2002, there were 1,155,342 women, ages 19-44 (27.2%), eligible for Title V in Texas. In that same year, there were 219,036 prenatal visits and 7,044 dysplasia visits.

Health Insurance Coverage: One out of every 10 persons in the United States who is uninsured lives in Texas. Over the last decade, Texas has consistently experienced one of the highest rates of uninsured in the United States, at approximately three times the national percentage. The state currently has the highest rate of uninsured in the United States. According to the 2002 Current Population Survey (CPS), data show that there were 5.6 million people without health insurance in Texas, about 26% of the total population. Data for 2001 from the Texas Health and Human Services Commission (HHSC) show that African Americans represent 11% of the Texas uninsured population and Hispanics are 59% of the uninsured. Healthcare coverage is also a significant issue among undocumented residents, the majority of whom do not have insurance. Among the total population in the Rio Grande Valley (HSRs 8, 9 and 11), 29% are uninsured. In the El Paso area (HSR 10), 30% of the population is uninsured. HHSC estimated that for 2001, approximately 66% of uninsured Texans were low-income (below 200% of the poverty level). As the table below shows, in 2001, Texas tied with New Mexico for having the highest rate of uninsured women – 28%, or about 1.8 million women – compared with a national rate of 18% (Kaiser Family Foundation).

Distribution of women 19-64 by health insurance status

Insurance Status	Texas #	Texas %	U.S. #	U.S. %
Employer	3,805,480	59	58,226,470	66
Self Insured	362,520	6	5,400,750	6
Medicaid	356,180	6	7,463,120	8
Medicare	82,470	1	1,726,770	2
Uninsured	1,813,156	28	15,643,139	18
Total	6,419,806	100%	88,460,249	100%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, 2001-2002

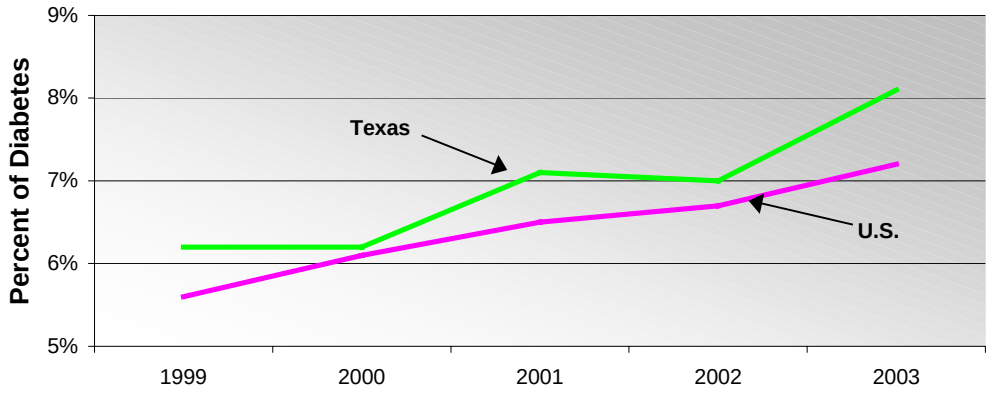
The following summary table of indicators displays most of the data reviewed in assessing the women and infant population by Health Service Region.

Needs Assessment Indicators for Women and Infants													
Health Indicators	**HSR1**	**HSR2**	**HSR3**	**HSR4**	**HSR5**	**HSR6**	**HSR7**	**HSR8**	**HSR9**	**HSR10**	**HSR11**	**TEXAS**	**US**
# Women Eligible for Title V Age 19-44	48,937	30,306	246,804	52,476	38,128	250,438	123,077	123,951	32,067	58,317	150,842	1,155,342	NA
# Live Births	12,300	7,275	100,756	14,452	9,929	88,564	39,455	36,193	8,141	14,478	40,826	372,369	NA
# Medicaid deliveries	6,401	4,473	48,986	9,528	4,692	47,295	15,614	19,304	6,515	8,669	31,638	203,351	NA
% First Trimester Prenatal Care	77.0%	83.4%	79.5%	82.8%	85.0%	81.3%	84.5%	87.1%	79.0%	66.9%	75.0%	80.5%	83.7%
% Low Birth Weight Births	8.9%	7.8%	7.6%	7.9%	8.2%	7.8%	7.2%	7.9%	8.7%	8.0%	7.3%	7.7%	7.8%
% Very Low Birth Weight Births	1.5%	1.1%	1.4%	1.4%	1.7%	1.4%	1.2%	1.4%	1.3%	1.0%	1.1%	1.3%	1.5%
Neonatal Mortality Rate, per 1,000 live births	4.8	5.6	4	5.1	4.3	3.9	3.8	4.1	4.4	1.9	3.2	3.9	4.7
Infant Mortality Rate, per 1,000 live births	7.9	9.5	6.3	8.5	8	6.3	6.1	6.8	7.7	3.7	4.9	6.4	7
Maternal Mortality Rate, per 100,000 live births	24.4	13.7	7.9	13.8	10.1	13.5	2.5	2.8	*	6.9	9.8	9.1	8.9
Fetal Death Ratio, rate per 1,000 live births	6.3	7.1	6.3	5.3	4	5.1	6	5.5	6.8	3.9	5.7	5.7	NA
Rate of HIV-only for Women Age 15-44, 2004	4.11	1.83	15.85	10.46	27.95	28.83	8.35	9.52	4.52	4.16	6.75	16.15	NA
Sudden Infant Death Syndrome Rate	0.33	0.96	0.71	0.69	1.11	0.32	0.61	0.66	1.6	0.14	0.32	0.56	0.51
Neural Tube Defect Rate per 10,000	8.13	11	5.86	8.3	4.03	6.77	5.83	8.57	4.91	4.83	5.63	6.47	5.79
Kessner Index of Adequate Prenatal Care	68.5%	73.9%	70.7%	75.4%	79.9%	71.6%	77.6%	83.1%	72.3%	54.1%	66.9%	72.3%	NA
% Breastfeeding WIC Enrollees, 2004	29.2%	29.3%	41.3%	33.5%	30.7%	48.0%	42.9%	30.9%	30.0%	40.3%	48.2%	41.3%	NA

*All data is from 2002 unless otherwise indicated. Source: DSHS, R&PHA

General health and well-being: In general, women and infants in Texas are not faring as well as their cohorts in other parts of the country. According to Behavioral Risk Factor Surveillance System (BRFSS) data for 2003, 23% of women ages 18 and over report five or more days or poor physical health (includes physical illness or injury) in the last 30 days. Almost 25% of women report five or more days of poor mental health (including stress, depression and emotional problems) in the last 30 days. Overall, this was reported more frequently in the African American population and among adults ages 18-29.

Diabetes: The diabetes rate is higher in Texas than nationally, with incidence higher among women (8.2%) than men and overall, highest among African Americans (10.5%).



Cardiovascular disease: In 2003, 33% of Texas women reported having high cholesterol and 24% reported having high blood pressure. Incidence of high cholesterol was highest among the White population, which may actually speak to who is getting screened. Incidence of high blood pressure was highest in the African American population.

Sexually Transmitted Diseases (STDs): Incidence of some sexually transmitted diseases is higher in women then in men. In 2003, there were 28,131 reported cases of chlamydia for all Texas females, which represents 84% of the reported cases. Incidence was highest among Hispanics (39%), followed by African Americans (24%), and then Whites (17%), and unknown (19%). Females represented 52% of the reported cases of gonorrhea. Forty-five percent of these cases were in the African American population, 21% were Hispanic, 16% were White and 17% were unknown. For Human Immunodeficiency Virus (HIV) infections, women represented 26% of the reported cases. Texas HIV infections have increased among women from fewer than 500 in the first quarter of 1999 to more than 1500 in the last quarter of 2003. Sixty percent of the 2003 cases were in the African American population, 21% were in the White population and 17% were in the Hispanic population. Women represented 22% of the Acquired Immunodeficiency Syndrome (AIDS) cases in Texas in 2003. Sixty one percent of these were in the African American population, 19% were in the White population and 18% were in the Hispanic population. Females represented only 25% of the reported primary and secondary syphilis cases in Texas. Sixty-six percent of these were in the African American population, 22% were Hispanic and 11% were White.

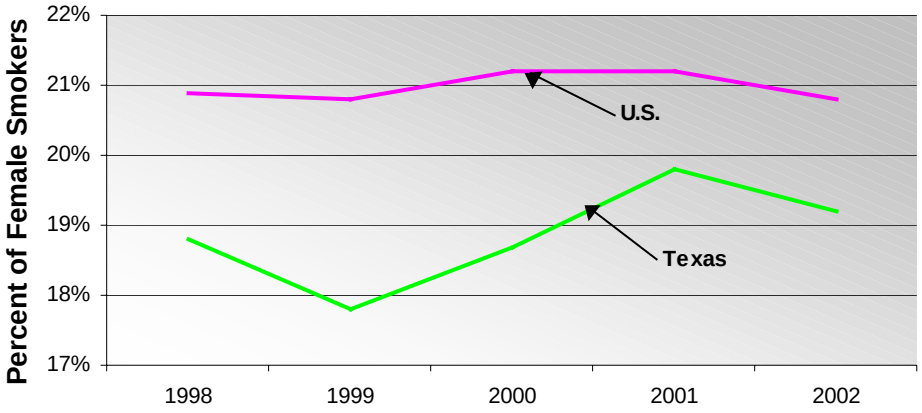
Family Violence: Violence against women presents a complex and costly problem for Texas. Recent statewide prevalence studies report that nearly 2 million Texans have been sexually assaulted and that 47% of Texans have experienced domestic violence. According to the Texas Department of Public

Safety in 2003, the highest rate of family violence victimization, 33.43 per 1,000, was among women, ages 20-29. domestic violence was cited several times in the Five Year Needs Assessment.

Behavioral risk indicators: Indicators of life style and personal choices reflect that Texas women may be at increased risk. BRFSS data from 2003 indicate that 55.3% of all women ages 18 and over are overweight or obese, having a Body Mass Index (BMI) of 25 or greater. Overall, incidence of overweight and obesity is highest among African Americans and lowest among Whites.

Twenty five percent of Texas women are obese (BMI 30 or greater), and incidence is again highest among African American women at 39.9%. The percentage of Texas women who are obese has increased annually since 1998 and is consistently higher than the national rate. In 2003, 60.7 % of Texas women did not meet recommendations for moderate of vigorous physical activity and 30.7% reported having no physical activity outside of work in the previous 30 days. The overall rate of women who eat five or more fruit and vegetable servings a day is 27.6 %, but is lower for Hispanics and young adults (ages 18-29). Another behavioral risk factor, especially for women of childbearing age, is intake of folic acid. BRFSS data from 2003 show that 46.3 % of women ages 18-44 take folic acid (either in a vitamin pill or supplement) as compared to 49.1 nationally. Among Hispanic women, 65.8 % report not taking folic acid. Among women ages 18-29, the percentage was 61.1%. Improving nutrition, increasing physical activity and reducing overweight and obesity was listed in the top six needs for the women and infant population. Stakeholders also mentioned the need to address diabetes and cardiovascular disease.

The overall percentage of smoking in Texas 22.1% is consistent with the national percentage, 22.2%. According to 2003 BRFSS data, 17.6% of Texas women ages 18 and older are current smokers. Generally, rates of smoking are higher among Whites and young adults ages (18-29).



The percentage of women, ages 18-44, at risk for binge or heavy alcohol use is 14.2%, which is fairly consistent with national rate (14.1%). Risk is highest among White women (18.3%) and women ages 18-29 (19.3%). Substance abuse and low birth weight/prematurity were in the top six needs for the women and infant population. Reducing fetal exposure to tobacco, alcohol and illegal substances were noted several times as possible activities to address these needs.

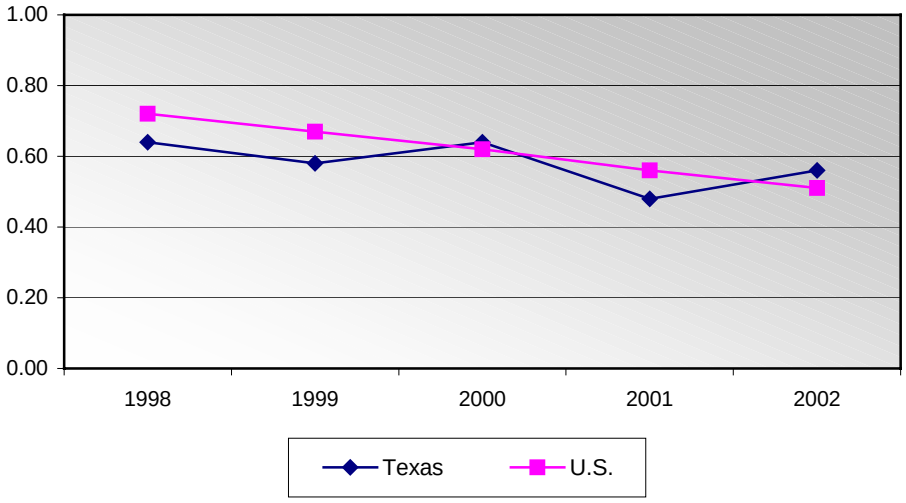
Perinatal Indicators: Some provisional data for 2003 are available, but will only be used when a comparison with national data are available. Otherwise, 2002 data are used. When considering perinatal indicators for Texas women and infants, there is a clear disparity for African Americans. Although the overall infant mortality rate (6.7 in 2003) is lower than the national rate (6.9), the African

American infant mortality rate at 14.2 is more than double that of Whites (5.9) and Hispanics (5.8). The overall fetal and neonatal mortality rates are also consistently lower than the national rates. In 2002, the Texas fetal mortality rate was 5.7 and the neonatal mortality rate was 3.9. However, a disparity again exists for African Americans with a neonatal mortality rate of 8.4, more than double the rate for Whites (3.3) and Hispanics (3.5).

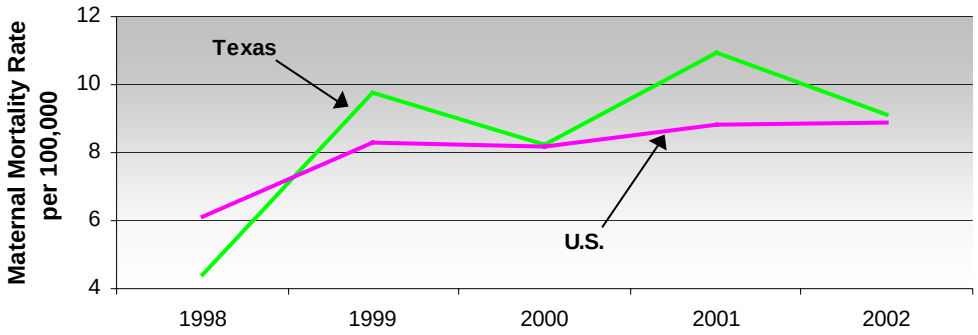
One cause of infant mortality is prematurity. In Texas, a disparity exists for prematurity in the African American population. The overall percentage of prematurity in Texas (10.3%) in 2002 was lower than the national average (12.1%). The percentage was 9.3% for Whites, 10.3% for Hispanics and 14.1% for African Americans.

Low birth weight often resulting from prematurity plays a role in infant mortality. The low birth weight percentage in Texas (7.7% in 2002) has also been consistently lower than the national average (7.8% in 2002), although in both instances, the percentage has increased since 1998. For singleton births, the White percentage was 5.3%, the Hispanic percentage was 5.8% and the African American percentage was 10.9%. A disparity also exits related to age, with the highest percentages of low birth weight among adolescents ages 10-14 (10.9%) and women ages 40 and over (8.4%).

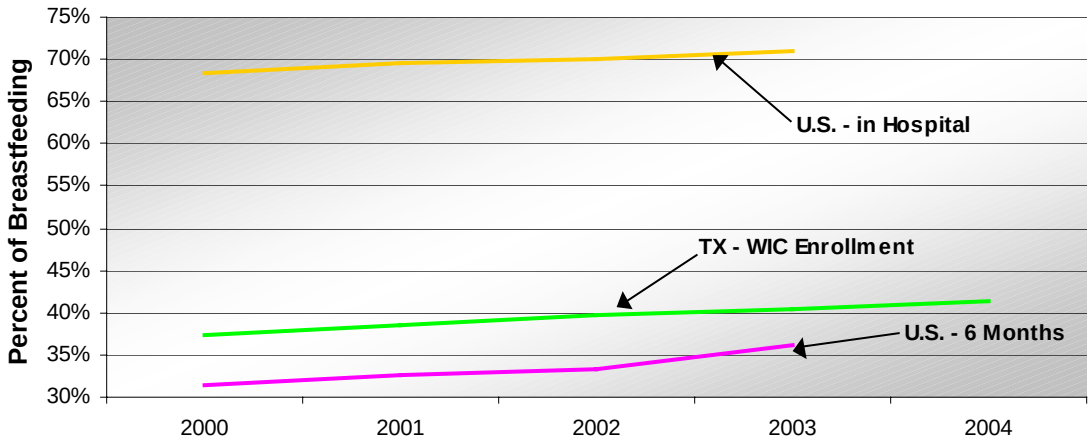
Another cause of infant mortality is Sudden Infant Death Syndrome. In 2002, SIDS was responsible for 8.8% of the infant deaths. For Whites, this represented .66 deaths per 1,000 live births; .40 deaths per 1,000 live births for Hispanics; and 1.01 deaths per 1,000 live births for African Americans. As with other perinatal indicators, a clear disparity exists for African Americans.



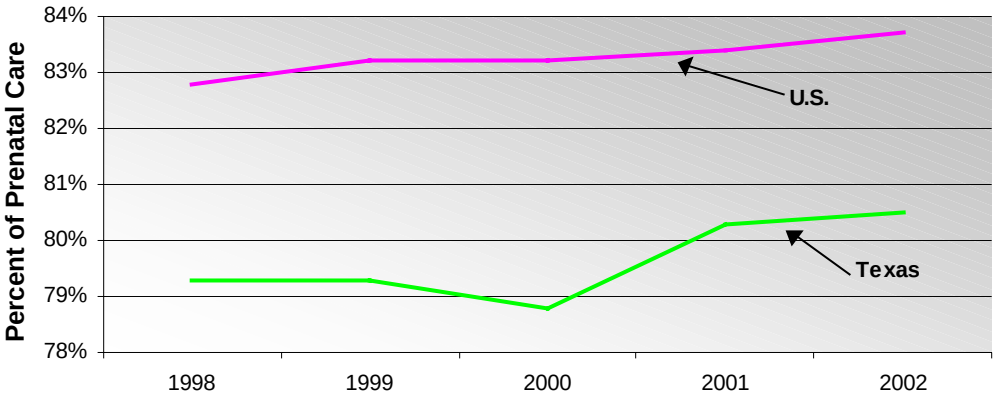
Since 1999, the Texas maternal mortality rate has been higher than the national rate, although the actual number of deaths was low (34). In 2002, the Texas rate was 9.1 per 100,000 births compared to a national rate of 8.9 per 100,000 births. When race/ethnicity and age are considered, disparities emerge for African Americans and for ages 30-40+. The maternal mortality rate for African American women in Texas in 2002 was 26.5 per 100,000 births while the rates for White and Hispanic women were 6.5 and 6.7, respectively. The rates from women ages 15-29 range from 4.7 to 6.1, while the rates for women ages 30-40+ range from 15.5 to 43.8.



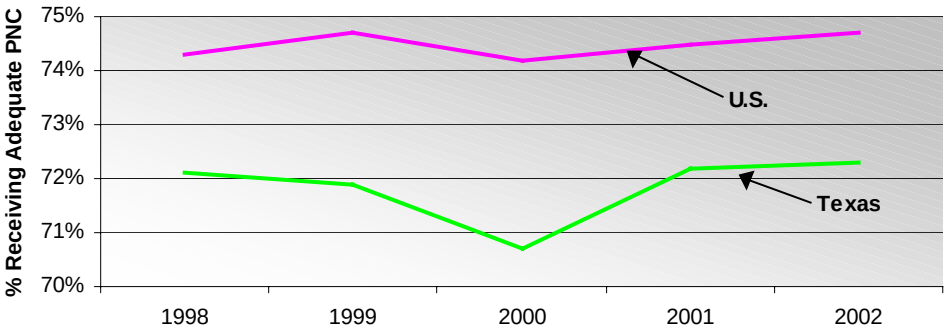
For data on breastfeeding, Texas relies on WIC certification records as the primary data source. Since mothers and babies can certify at different times, it is difficult to make a comparison to United States data, which is for hospital discharge and at six months after delivery. In 2003, 40.5% of postpartum WIC enrollees were breastfeeding at the time of certification. National statistics indicate that 70.9% of women were breastfeeding at hospital discharge and 36.2% were breastfeeding at six months. When compared to the Healthy People 2010 targets for breastfeeding of 75% at hospital discharge, 50% at six months and 25% at one year, available Texas data could indicate need for improved data collection for an accurate assessment of breastfeeding percentages. In the Five-Year Needs Assessment, increasing the breastfeeding rate was one of the five needs cited.



Access to care: One method of measuring access to care is to examine the rates of screening for various risk factors and illnesses. Current data indicate that the number of African American and Hispanic women screened for risk factors as hypertension and high cholesterol and diseases, such as breast and cervical cancer is lower than for Non-Hispanic Whites. For example, 2003 BRFSS data show that 28.2 % of women age 18 and over have not had cholesterol screening in the past five years. Overall, this percentage is highest among Hispanics (48.8%) and lowest among Whites (23.2%). Another method is to measure the onset and adequacy of prenatal care. The overall onset of prenatal care in the first trimester steadily improved in Texas from 79.3% in 1998 to 80.5% in 2002, although it has consistently been lower than the national rate (83.7% in 2002). White women have the highest rate of first trimester onset at 87.8% while African American women are at 76.8% and Hispanic women have the lowest rate at 75.1%.



As measured by the Kessner Index, the adequacy of prenatal care in Texas was 72.3% in 2002. Measuring by Adequacy of Prenatal Care Index (Kotelchuck Index), Texas was 70.3% adequate or above as compared to 74.7% nationally. In 2003, the rate remained the same for Texas, with the rates for White women 79.1%, for African American women, 66.4% and for Hispanic women, 63.8%. A disparity exists for Hispanic women (10.4%) and adolescents, ages 10-14 (16.1%). In the Five-Year Needs Assessment, access to prenatal care was the most commonly cited need and overall access to care/increasing providers was the third.



The following table considers many of the relevant health indictors for the women and infant population by race and ethnicity.

Needs Assessment Indicators for Preventative and Primary Care for Women and Infants						
Health Indicator	**White**	**African American**	**Hispanic**	**Unknown or Other**	**Texas**	**U.S.**
Five or more days of poor physical health in past 30 days*	22.6%	24.5%	23.5%	20.5%	23%	21.2%
Five or more days of poor mental health in past 30 days*	24.8%	27.8%	22.4%	31.5%	24.6%	22.9%
Diabetes*	7.4%	12.0%	8.6%	6.7%	8.2%	7.4%
High cholesterol*	36.4%	32.2%	24.4%	29.5%	33%	32.4%
High blood pressure*	25.8%	39.0%	16.6%	16.3%	24%	25.6%
Chlamydia, percent of reported cases	17%	24%	39%	19%	84%	**
Gonorrhea, percent of reported cases	16%	45%	21%	17%	52%	**
HIV, percent of reported cases	21%	60%	17%	2%	26%	**
AIDS, percent of reported cases	19%	61%	18%	2%	22%	**
Syphilis, primary and secondary, percent of reported cases	11%	66%	22%	1%	25%	**
Overweight, BMI 25 or greater*	48.5%	72.7%	65.6%	42.6%	55.3%	51.5%
Obesity, BMI 30 or greater*	21.8%	40.6%	28.6%	11.7%	25.1%	22.4%
Physical activity, did not meet recommendations*	55.0%	69.9%	68.0%	63.9%	60.7%	54.7%
Physical activity, none outside or work in past 30 days*	24.3%	36.6%	41.5%	28.5%	30.7%	27.0%
Fruits/vegetables, did not eat five servings or more daily*	70.7%	70.0%	76.6%	69.8%	72.4%	72.5%
Folic acid, not taken in vitamin or supplement*	35.1%	56.1%	62.5%	54.6%	45.7%	45.8%
Smoking*	22.3%	13.4%	10.0%	19.2%	17.6%	19.6%
Binge drinking or heavy alcohol use*	11.5%	8.4%	8.7%	6.7%	10.2%	9.9%
Infant mortality, rate per 1,000 live births, 2003	5.9	14.2	5.8	***	6.7	6.9
Fetal mortality, rate per 1,000 live births, 2002	**	**	**	**	5.7%	**
Neonatal mortality, rate per 1,000 live births, 2002	3.3	8.4	3.5	1.8	3.9	4.7
Prematurity, 2002	9.3%	14.1%	10.3%	8.7%	10.3%	12.1
Low birth weight, 2002	5.3%	10.9%	5.8%	***	7.7%	7.8%
Very low birth weight, 2002	0.80%	2.30%	1.00%	***	1.30%	1.5%
Sudden Infant Death Syndrome (SIDS), 2002	0.66	1.01	0.4	0.21	0.56	0.51
Maternal mortality, per 100,000 births, 2002	6.5	26.5	6.7	14	9.1%	8.9
Breastfeeding, WIC enrollees, April 2004	30.5%	26%	51.5%	***	44.4%	NA
Cholesterol screening, no screening w/in past 5 years*	20.6	24.9	42.8	36.9	28.20%	23.7
First trimester onset of prenatal care, 2002	87.8%	76.8%	75.1%	***	80.5%	83.7%
Percent receiving adequate prenatal care (Kessner), 2002	81.4%	68.1%	65.4%	***	72.30%	**
Adequacy of prenatal care (Kotelchuck), 2003	79.1%	66.4%	63.8%	**	69.6%	**

Data is for 2003 unless otherwise indicated. *BRFSS 2003 data ** Data not available ***Included with White

Assessment of stakeholder input ***(qualitative data needs)*** for women and infants

The following summaries of the ***qualitative data needs*** were derived from stakeholder input for the women and infant population and state how the input is linked to the selection of state priority needs and the development of activity plans.

Summary of Attachment C – ***qualitative data needs*** from stakeholder input, Part II-a, women and infants

A total of 74 respondents identified almost 150 need areas for the women and infant population of Texas. An overwhelming majority of the responses (approximately 95%) were related to infrastructure building and population-based services. Recurrent themes expressed for population-based services were related to breastfeeding, prenatal care, infant mortality, nutrition/physical activity, screening procedures and injury prevention. Most of the recurrent themes for infrastructure building were related to prenatal care, healthcare infrastructure, parenting, prematurity, and obesity. Although input for all four types of the pyramid services varied widely, a recurrent theme was the need to reform public assistance programs to increase Medicaid enrollment, expand Medicaid and CHIP coverage, and to facilitate ease of enrollment in both of these programs. Much of this work is out of the scope of the Texas Title V program, however, and can only be addressed through the Texas legislature or by the HHSC.

The most commonly identified need across the pyramid level of services was to increase access to prenatal care (24 responses). Suggested activities were the following:

- increase the number of providers,
- provide Spanish-language services,
- work within communities to reduce barriers to care, and
- ensure that the general public is aware of the need for prenatal care and how to access it.

The second most frequently identified need was to increase access to health care in general (14 responses). Suggested activities were to

- increase the number of providers,
- assure a medical home for clients, and
- provide services for undocumented residents.

The third most frequently identified need was preventing low birth weight and/or prematurity (13 responses). Frequently recommended activities were to

- identify high-risk mothers,
- increase public awareness,
- educate clients and providers, and
- screen for high-risk behaviors and conditions.

Rounding out the top six most frequently identified needs were increasing breastfeeding (11 responses), improving nutrition or addressing obesity (11 responses) and reducing substance abuse (9 responses).

The overall message from stakeholders who completed the survey is that there is a high need for infrastructure-building services and improvements that increase public awareness of MCH issues. If implemented, many stakeholder activities would ultimately make healthcare more accessible and affordable, reduce substance use and obesity, and hopefully lead to improvements in the measures for breastfeeding, low birth weights, prematurity, and violence against women. This input from stakeholders was strongly considered in determining ***critical needs*** that were later prioritized by stakeholders, as discussed in section II.B.5., Selection of State Priority Needs, and in the development of state activity plans that focus on infrastructure and population-based services.

Summary of Attachment D – stakeholder input from Part III, NPM activities for women and infants.

Stakeholders suggested a multitude of activities to improve breastfeeding rates, to reduce low and very low birth weights, and to improve prenatal care. Many of the suggested activities were related to increasing public awareness through

- public campaigns,
- educating mothers and providers,
- improved collaboration of service providers to make services more comprehensive and therefore leverage resources, and
- improving outreach methods through use of models such as promotoras and other community health workers.

Activity plans developed for FY06 plans reflect many of these suggested activities. For example, FY06 activities for NPM 11 (breastfeeding) include

- improved community access to education for breastfeeding, especially for African American mothers; assisting hospitals and birthing centers in becoming accredited for Texas Ten Step designation to promote breastfeeding;
- providing breastfeeding and training resources to physicians and other health care professionals, and
- assisting Texas worksites to become designated as mother-friendly through the Mother Friendly Worksite Program.

Activities designed to address the issue of very low birth weights and very low birth weight infants delivered at facilities for high-risk deliveries (NPMs 15 and 17) include

- use of Geographic Information Systems to identify the areas of the state with the highest incidence of low and very low birth weights;
- allocation of funds through a competitive RFP to those areas;
- continuation of work with Texas Healthy Start projects to implement a peer counselor/promotora model for high-risk women;
- continuation of work with the March of Dimes Prematurity Campaign; and
- tracking of referral patterns to assure that high-risk women are served at facilities equipped for high-risk deliveries.

Activities designed to address prenatal care (NPM 18) are to target two health service regions with low utilization of early prenatal care by allocating funds for projects that can improve birth outcomes in those areas.

After ***quantitative data needs*** were thoroughly reviewed and stakeholder input was analyzed, MCH subject matter experts then compared the ***qualitative data needs*** to the ***quantitative data needs*** to determine the ***critical needs*** for women and infants in Texas, and again stakeholders were asked to prioritize the critical needs in order to select final priorities for the state. A discussion of the critical needs and the results of the stakeholder prioritization (Attachment F) is in section II. B. 5., the Selection of Priority Needs.

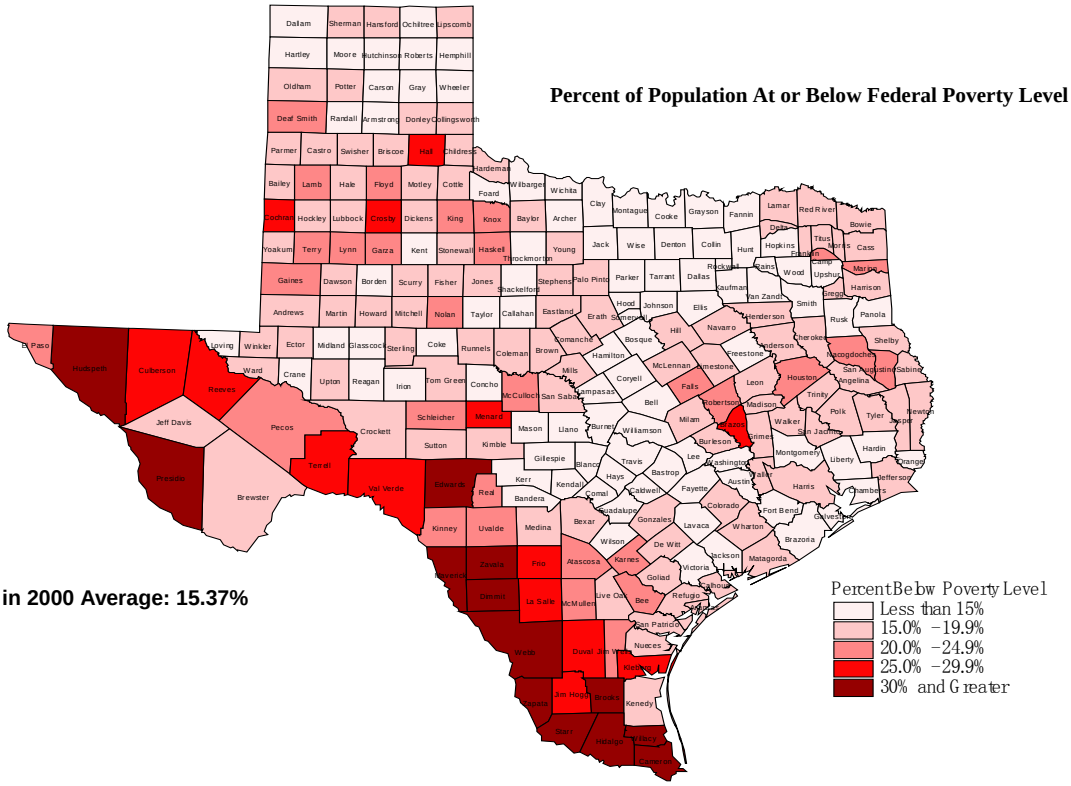
Children and Adolescents

Assessment of *actual needs*

The following assessment of ***quantitative data needs*** was performed by Title V MCH subject matter experts after an extensive review of health and capacity data.

In 2001, more than 6.6 million children and adolescents age 0-19 resided in Texas and of those children, 1.5 million were eligible for Title V services. In Texas, 20.2% of children and adolescents under age 18 live below poverty level. The map below shows the Texas Counties in relationship to the percent of population at or below the Federal Poverty Level. In the health service regions (HSR), some of the higher percentages of poverty levels were 39.6% for Region 11, 31.6% for Region 10 and 22.5% for Region 8.

Percent of Population At or Below Federal Poverty Level - 2000



Texas Statewide in 2000 Average: 15.37%

In 2001, 21% of children under age 18 were uninsured and another 22% were insured through Medicaid or Texas Children's Health Insurance Program (CHIP). The remaining 56% were insured through private insurance or Medicare. Texas ranks last in the nation in the percentage of children insured. About 41% of uninsured children in Texas are below 100% of poverty. Overall in 2001, 59% of Hispanic children, 29% of White children, and 11% of African American children were uninsured. Texas children who lack health insurance are less likely to be fully vaccinated than children with public or private insurance. Currently, 122 of 254 Texas counties are designated as health professional shortage areas. Only 46% of Texas physicians are accepting new Medicaid patients; therefore, even if services are available in a county, children covered by Medicaid or CHIP may not be able to access care. One half of children born in Texas are initially covered under Medicaid.

Three of the major issues that impact the status of Texas children and their families are the geographic size of Texas, the size and diversity of the population, and the recent reorganization of state agencies delivering health and human services. The geographic size of Texas presents a major challenge in that all persons in the state do not have equal access to services. Texas is 790 miles long, 660 miles wide and encompasses almost 260,000 square miles and 254 counties. As discussed in the assessment for women and infants, 79% of Texas counties are designated as rural or frontier, and 176 counties (69%) are designated as medically underserved areas. Although the population diversity is a strength, the associated language barriers and wide array of social and cultural norms definitely impact service provision to children and families. Based on 2000 census figures, Texas is now the 2nd most populous state in the U.S. with a total population of 20,851,820. There are approximately 2,068,032 children from birth to five years of age. There are 21,335,018 youth between the ages of 13 to 18, and 366,678 live below the poverty level. The implication of these numbers is that there is a high need for efficient, effective, coordinated systems of care to provide services to the maternal and child health population. Last but not least, the recent reorganization and consolidation of twelve Texas Health and Human Services agencies effective in 2004 has a long-term goal of reducing administrative duplication and promoting opportunities for Title V and other programs to work more collaboratively. Until the consolidation is stabilized and new roles and responsibilities are fully functional, DSHS and other state agency staff have the additional challenge of continuing to provide quality services while undergoing the agency's transformation.

The following Summary Table for Children and Adolescents displays most of the data reviewed in assessing the children and adolescent population.

Summary Table for Children and Adolescents

By Health Services Region

Needs Assessment Indicators For Children and Adolescents													
Health Indicators	**HSR1**	**HSR2**	**HSR3**	**HSR4**	**HSR5**	**HSR6**	**HSR7**	**HSR8**	**HSR9**	**HSR10**	**HSR11**	**TEXAS**	**US**
Deaths to Children Ages 1-14 (02)	23.4	27.2	22.3	39	30.9	21.4	21.9	23.8	22.6	19.7	23.2	23.3	21.2
Homicide Rate (02)	1.2	2.9	1.3	1	3.4	2	1.3	2.1	1.8	1.7	1.1	1.7	0.4
Suicide Rate ages 5-14 (02)	0.9	2.7	0.6	1.4	0.9	0.6	0	1.2	3.7	0	0.3	0.7	0.6
Sucide Rate ages 15-24 (02)	10.4	7.8	8.2	14.5	11.5	12.2	8.7	9	15.3	4.2	7.6	9.6	9.9
Chid Abuse/Neglect Rate ages 0-17 (04)	15.1	14.8	7.9	10.7	8.6	6.1	10.6	7.6	9.3	3.7	9.3	8.3	NA
# Children eligible for Title V ages 1-12	32,153	19,847	174,239	35,726	24,647	168,882	70,795	82,858	21.413	35,429	83,052	749,040	NA
# Children eligibe for Title V ages 13-21	35,350	21,976	150,441	33,558	26,050	153,297	84,769	80,569	23,907	35,545	90,799	736,261	NA
# Teen pregnancies ages 13-17 (02)	13,888	8,060	123,445	15,599	11,413	109,429	48,679	45,253	9,097	16,502	46,099	23,311	23.2
# Children received Dental Services '03	22,547	16,248	159,912	30,250	23,014	197,285	50,450	104,025	15,426	49,579	164,990	833,726	NA
# Children received THSteps Screens '03	26,105	16,945	153,297	37,553	24,854	159,343	50,844	80,113	20,523	40,534	169,418	785,529	NA
Obesity % WIC ages 1-4 2005	9.80%	8.60%	9.30%	11.00%	9.40%	10.60%	9.00%	11.00%	6.90%	8.70%	11.80%	10.30%	NA
% of Children 19-35 Mos. 4:3:1:3 Series (03)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	68.7	81

Summary Table for Children and Adolescents

By race/ethnicity

Needs Assessment Indicators Children and Adolescents						
Health Indicators	**White**	**Black**	**Hispanic**	**Other/unk**	**Total**	**Year**
Teen Pregnancy Rate	14.1	34.8	44.6	11.1	28.5	2002
Child Abuse/Neglect Rate Ages 0-17	7.6	13.8	7.5	6.7	8.3	2004
Deaths to Children Ages 1-14	21.7	32.5	22.3	na	23.3	2002
Homicide - Children	1.3	4.4	1.2	1.3	1.7	2002
Suicide - Children (5-14)	0.8	0.4	0.6	1.9	0.7	2002
Suicide - Youths (15-24)	13.4	5.2	7.3	4.5	9.6	2002
% Obesity - WIC Children (Age 1-4)	7.3%	7.1%	11.4%	6.8%	10.3%	2002
% Children Receiving Dental Services	24%	18%	50%	8%	100%	2002
% Receiving THS checkup	24%	18%	50%	8%	100%	2002

Health care Infrastructure

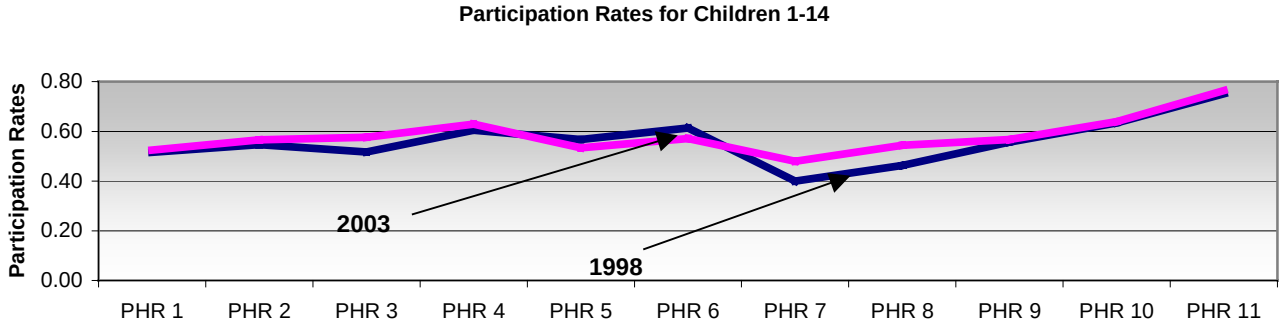
Access to care

As of May 2005, 2.7 million Texans were enrolled in Medicaid, and 1.8 million were children, of which 4.5% were receiving disability-related Medicaid and about 13,000 were pregnant teens (Center for Public Policy Priorities).

EPSDT (THSteps)

In 2003, the number of recommended checkups for children aged 1 to 14 had increased to 14 from 11 in 1998 and the number of children aged 1-14 receiving checkups had increased 58%. However, even with the increase in recommended screens and a 30% increase in the number of eligible, participation for Texas children aged 1 to 14 improved 16%, from 52% in 1998 to 60% in 2003. The graph below shows the participation rates by region for 1998 and 2003.

Participation in every region increased except for HSR 6, which decreased slightly, and HSR 10, which remained stable over the five-year period. In both years, the region with the lowest participation rate was HSR 7 and the region with the highest participation rate was HSR 11. In 2003, HSR 11 had a participation rate of 76%. (*Note: Public Health Region (PHR) is the former designation for Health Services Region (HSR).



Dental

Currently, no statewide data are available on the prevalence of tooth decay in Texas for adults or children; however, in 2001, the University of Texas Health Science Center Dental Branch completed a dental study of children in seven counties around Houston. In all, 292 pre-kindergarteners were studied. The highest prevalence of untreated tooth decay was 54.3% of those in pre-kindergarten and lowest was 28.3% of those in pre-kindergarten. In 2003, only 47% of Texas Health Steps eligible recipients age 1-14 received oral health screens. Children aged 1-14 in the Texas Health Steps Medicaid program are recommended to have two prophylactic dental exams each year, with additional preventive treatments such as sealants, and treatments for more serious dental problems as needed.

The number of children age 1-14 receiving dental services in Texas increased from 557,364 to 833,726 from 1998 to 2003. The percentage of children receiving services during those five years increased in every region except HSR6; which remained at 52%. HSR6 had the highest percentage of children receiving dental services in 1998 (52%) and

the second highest percentage in 2003, surpassed only by HSR11, which increased to 56%.

Title V
Title V-funded child health clinics provided preventive and comprehensive care to approximately 13,898 unduplicated clients in FY 04. These clients received a total of 25,714 visits for an average of two visits per client. Title V population-in-need estimate for 2004, which excludes Medicaid eligible, reveals that the greatest need for services are located in Dallas (HSR3), Houston (HSR 6), and San Antonio (HSR 8). The total number of unduplicated clients served for dental health was 7,623.

Newborn Screening
The Texas Newborn Screening Program (NBS) tests for five disorders; including the two inborn errors of metabolism, phenylketonuria (PKU) and galactosemia, congenital hypothyroidism, congenital adrenal hyperplasia (CAH), and sickle cell disease. The program is cost effective, preventing 200 newborns from mental retardation each year and lowering chances of morbidity and mortality of all affected infants. All babies born in Texas are required to have two sets of screening tests, within 48 hours of birth and again at approximately 2 weeks of age. This includes the initial tests, the second screening and requested repeats because of abnormal initial results.

An active Case Management program provides for follow-up on all abnormal reports. Health care providers are contacted by telephone and/or fax and parents are notified by letter. Regional and local public health nurses and social workers are often utilized to help locate families and assist with follow-up procedures.

Newborn Hearing Screening
Texas has a model program for newborn hearing screening and the mandates are the strictest in the nation**.** In 2004, the percentage of newborns that were screened for hearing impairment before hospital discharge was 80.5% or 306,286 newborns screened out of 380,367 births.

Mental Health Screening
In 2002, 150,481 Texas children and adolescents under the age of 18 had a diagnosis of mental illness defined as exhibiting severe emotional or social disabilities that are life-threatening or require prolonged intervention. In 2003, an invitation to the DSHS to participate in an Adolescent Health Leadership Forum in collaboration with the American Academy of Pediatrics was extended. The Federal Maternal and Child Health Bureau (MCHB) and the Center for Disease Control and Prevention (CDC) sponsored the meeting to support expansion of pediatricians' capacity to collaborate with other health care professionals, public health officials and policy makers with the intent of increasing positive lifestyle behaviors among youth. In an effort to address the limited capacity of healthcare providers who treat mental illness in children and youth in Texas, a workgroup formed to focus on reducing mortality and morbidity related to mental illness and substance abuse. The workgroup was comprised of the DSHS staff and external stakeholders, representing universities, mental health specialists, primary care physicians

including pediatricians, and other state agencies such as the Texas Education Agency. The workgroup is exploring a pilot study whereby primary care physicians will screen, treat and/or refer for mental health services.

In March 2004, the Texas Education Agency surveyed all public school campuses in Texas; 3,847 of about 8,000 public school campuses (48%) responded. Along with background of the state of mental health and substance abuse programs for children, Assessments of Existing School-based Mental Health and Substance Programs Report (Attachment G) presents survey findings, insight from a meeting of 30 stakeholders organizations, and recommendations for future direction. The summary of findings revealed:

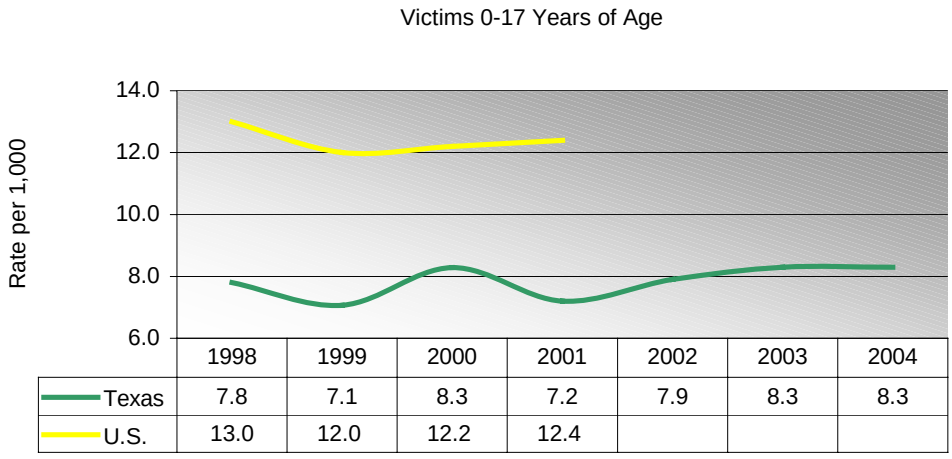
- At all grade levels, schools cited counseling as their most successful approach to identifying and addressing student's mental health and substance abuse problems.
- School counselors spend most of their work time on task other than mental health and/or substance abuse counseling, especially in high schools.
- Schools cited a variety of prevention and intervention programs, but no statewide standard for mental health and substance abuse programs exist.
- Most schools provide students and families with resource information and referrals to a wide range of mental health and substance abuse programs. No mechanisms exist to track whether referrals result in care.
- Almost three-fourths of school campuses had been trained in the Texas Behavior Support Initiative, designed to provide positive behavior support for students, especially those with disabilities.
- Schools generally rated themselves as successful or fairly successful in providing resource information and referrals for students with mental health and substance abuse problems, and as moderately or fairly successful in identifying students and providing school-based services for them.
- Stakeholders identified components of successful school-based mental health and substance abuse programs, including adequate funding, program evaluations, and the presence of mental health and substance abuse professionals on staff at all grade levels, training for families and school staff, and linkages to community-based services.

The recommendations included:

- Charge local school health advisory councils with exploring the coordination of mental health and substance abuse needs and services for their districts.
- Encourage local school boards to adopt policies on positive behavior support to improve campus environment.
- All teachers should received service credit hours or continuing education hours for training in early identification of students with mental health and/or substance abuse problems.
- Encourage the expansion of the wrap-around process for children's mental health services.

Immunizations
Vaccination coverage among Texas children ages 19-35 months was 68.7% in comparison to the United States of 81.0% in 2003. The percent of children 19-35 months of age with 4:3:1:3 series in Texas has slightly decreased each year from 1998 thru 2003, except in the year 2001. Texas percentages are consistently lower than national numbers and a disparity exist for African-American and Hispanic children in Texas. Of the vaccine preventable disease, whooping cough is now on the rise in Texas.

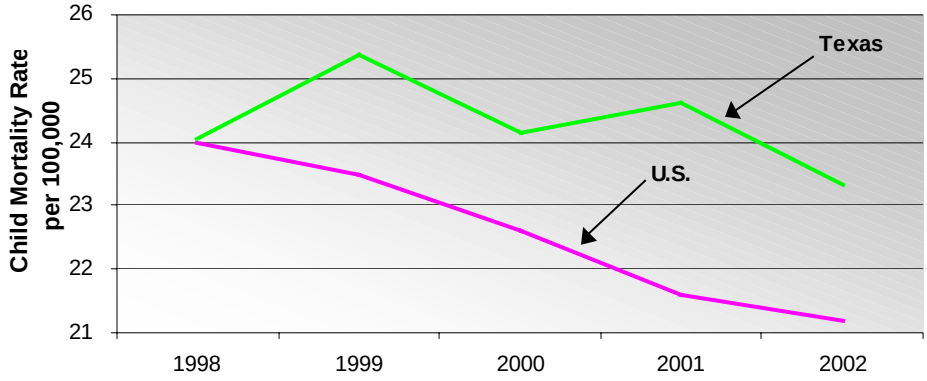
Injury Prevention/Violence Prevention
Child Abuse/Neglect
In 2004, the incidence rate of confirmed victims of child abuse and/or neglect for ages 0-17 was 8.3. The incidence rate was highest among African Americans at 13.8, followed by Whites at 7.6 and Hispanics at 7.5. Infant's less than 1 year of age had the highest rate at 19.3, with incidence rates decreasing as age increased. The total number of confirmed victims of child abuse and/or neglect in Texas was 50,529 in 2004. The rate of confirmed victims of child abuse and/or neglect for ages 0-17 has varied in Texas each year from 1998 through 2002 between 7.8 in 1998 to 8.3 in 2003 and 2004. The rate for Texas is consistently lower than the national average. In 2004, the Department of Family Protective Services reported 289,847 child abuse/neglect investigations.



	1998	1999	2000	2001	2002	2003	2004
Texas	7.8	7.1	8.3	7.2	7.9	8.3	8.3
U.S.	13.0	12.0	12.2	12.4			

Unintentional Injuries
In 2000, unintentional injuries were the leading cause of death for ages 1-34. The child death rate in Texas was consistently higher than the national average for each year during 1998-2002. The Texas death rate for children 1-14 years was dramatically higher in the 1-4 year old group (34.3) than in the 5-9 or 10-14 year old age groups, which were15.9 and 22.0 respectively. African American children in Texas had a higher mortality rate

(32.5) than Whites (21.7) or Hispanics (22.3).



Motor vehicle accidents

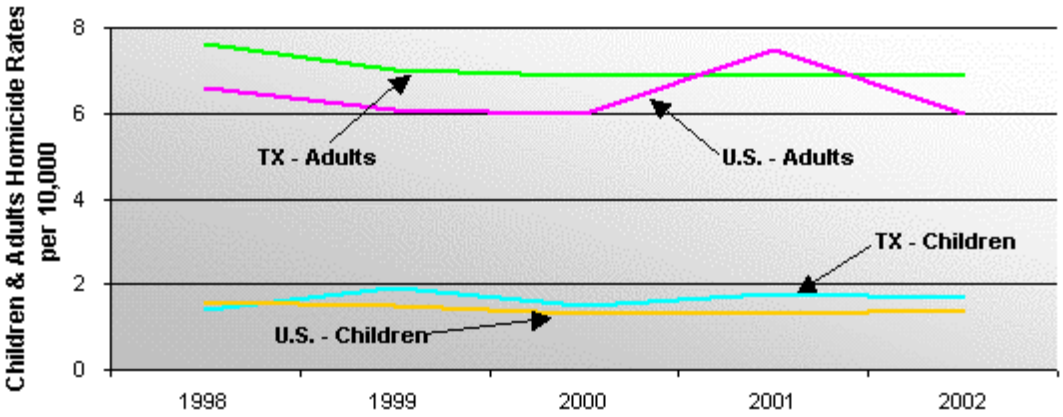
The rate of fatal unintentional injuries due to motor vehicle accidents in Texas is consistently higher than the national average. Children aged 1-4 have the highest number of motor vehicle deaths at a rate of 6.1 and the second highest rates is for ages 5-9 at 4.2; however, motor vehicle crashes are the leading cause of death among children ages 5 to 9. Child safety seats reduce the risk of death for infants by 71% and 45% for toddlers. According to the Children's Safety Network, for children ages 0-4, every $45 child safety seat saves $85 in medical expenses and an additional $1,275 in other costs, including tangible and quality of life costs.

Texas 2003 YRBS data, excluding Houston ISD indicated that the prevalence of rarely or never wearing seatbelts as a passenger decreased from 10.4% in 2001 to 7.9% in 2003. Overall, male students 10.9% were more likely than female students 4.8% to have rarely or never worn seat belts.

Also, the report revealed the percent of students who rode in a car or other vehicle driven by someone who had been drinking alcohol one or more times during the past 30 days preceding the survey decreased from 40 percent in 2001 to 32.9 percent in 2003. The percent of students who drove a car after drinking alcohol during the past 30 days preceding the survey decreased from 16 percent to 12 percent in 2003.

Homicide

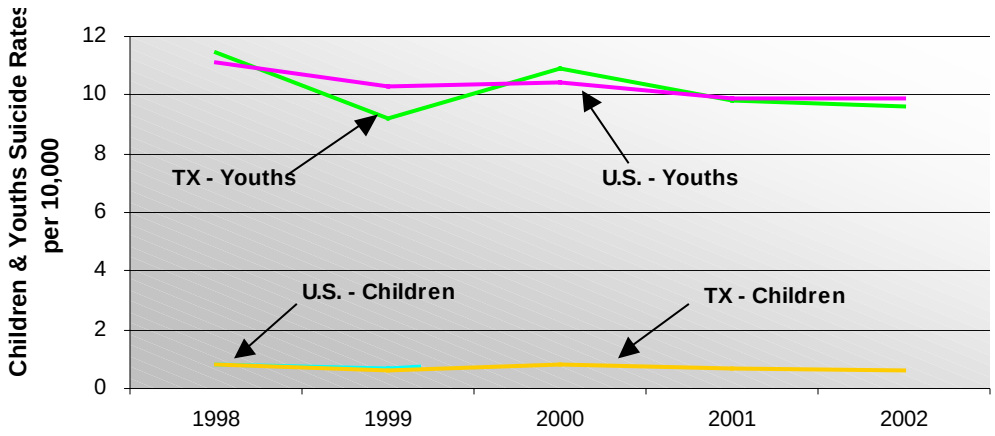
In Texas, the child homicide rate fluctuated from 1998 through 2002, while adult homicide rate decreased from 1998 to 2000 and then remained unchanged through 2002. During 1998-2002, the homicide rate in Texas was higher than the national average homicide rate for both children and adults.



In Texas, there were 78 homicide deaths to children ages 1-14 in 2002, for a homicide rate of 1.7 per 10,000 populations. In 2002, there were 921 homicide deaths to adults ages 25 or more and the homicide rate dropped to 6.9 in 2002 compared to 7.6 in 1998. A disparity exists for African Americans. African American children and adults who both had significantly higher homicide rates than the Whites, Hispanics or other children and adults.

Suicide

In Texas, the suicide rate for children (5-14) and youths (15-24) both fluctuated from 1998 through 2000, and then decreased from 2000 through 2002. The children suicide rate in Texas was slightly higher than the national average for each year during 1998-2002.



In Texas, there were 24 suicide deaths to children ages 5-14 in 2002, for a suicide rate of 0.7 per 10,000 population; 322 suicide deaths to youth's ages 15-24 in 2002 and the suicide rate dropped to 9.6 in 2002 compared to 11.5 in 1998. White children and youths had higher suicide rates than black or Hispanic children and youths.

Obesity
Two out of three Texas adults are overweight or obese. One Texas school-age child out of three is overweight or obese. Today's Texas children could be the first generation in one hundred years to have shorter life spans than their parents. If the trend is not reversed, the number of overweight and obese adults will double to 20 million by the year 2040.

In Texas 2005, the incidence of obesity was much higher for Hispanic children (11.4%) than for white (7.3%) or black (7.1%) or other (6.8%) children. An average 10.3% of all WIC children ages 1-4 are overweight, 9.8% of all WIC children ages 1-4 are at risk for becoming overweight. In 2005 WIC data, Texas HSR11 has the highest percentage of WIC children who are obese and HSR 9 has the lowest percentage.

The percentage of overweight adolescents age 14 through 18 increased between 1999 (10.5%) and 2001 (14.2%) and has shown a slight decrease in 2003 (13.9). Adolescents of Hispanic origin had the highest percentage in both 2001(17.6%) and 2003 (16.5) and Whites the lowest in all years (1999-2003). African Americans had the highest percentage (16.8) in 1999.

Texas 2003 YRBS data (excluding Houston ISD), indicate that the percentage of students who are at risk for becoming overweight increased from 14.8% in 2001 to 16.4% in 2003. The proportion of students who are at risk for becoming overweight is greater among African American (18.9%) and Hispanic students (18.7%), than White students (13.7%). No differences exist among students by gender and grade levels.

Risk Behaviors
Youth Behavior Risk Survey (YRBS – Attachment H)
In the spring of 2003, the Department of State Health Services (formerly the Texas Department of Health), in cooperation with the Centers for Disease Control and Prevention, conducted a statewide school-based Youth Risk Behavior Survey that resulted in 4,075 questionnaires completed by students in 49 public high schools. The results are representative of all students in grades 9 through 12 (excluding students enrolled in the Houston Independent School District because of inadequate overall school response rate).

Dating Violence
During the 12 months preceding the survey, 8.5% of students surveyed in Texas, as compared to 8.9% nationally, had experienced dating violence.

Forced Sexual Intercourse
In Texas, 7.7% (9.0% nationally) of students were physically forced to have nonconsensual sexual intercourse. Overall, the prevalence of nonconsensual sexual intercourse in Texas was higher among females (11.2%) than males (4.4%) students. Nationally, the prevalence of nonconsensual sexual intercourse was higher among white females (11.2%) and Hispanic females (13.0%) than white males (3.7%) and Hispanic male (7.6%), and higher among 9th grade females (11.3%), 11th grade females (13.5%),

and 12th grade females (11.6%) than 9th grade male (5.0%), 11th grade male (4.8%), and 12th grade males (6.6%). Overall, the national prevalence of nonconsensual sexual intercourse was higher among African Americans (12.3%) and Hispanics (10.4%) than White (7.3%) students, and higher among African American male (11.7%) and Hispanics males (7.6%) than White males (3.7%) students.

Alcohol
The percent of students who had had five or more drinks of alcohol on more than one occasion during the 30 days preceding the survey (episodic heavy drinking) decreased from 31 percent in 2001 to 25.7 percent in 2003.

Tobacco
In 2001, smoking was highest overall among grade 11 students, with a steady increase in the percent of smokers in all ethnic groups in grades 9 through 11, followed by an overall decline in grade 12. Smoking was highest among Hispanic students in all grades, and the percentage increased from grade 9 through grade 12. In 2001, Smoking among students in Texas was slightly higher than the national average (15.6% vs. 15.2%). Except for White students, smoking among Texas students for all other ethnic groups was higher than the national average. However, the YRBS revealed that lifetime use of cigarettes decreased from 66 percent in 2001 to 59.4 percent in 2003.

Teen pregnancy
Although national and state teen pregnancy rates have declined during the past decade, the issue of teen pregnancy rates remains high in Texas. In 2002, Texas was the highest among all states in the nation in teen birth rate for ages 15 - 17. Racial and geographic disparities in teen birth rates, an increase in the number of low birth weight infants born to teen mothers, and an increase in the proportion of sexually transmitted diseases among teens represent challenges that must be addressed through a comprehensive approach to impact teen pregnancy through responsible sexual behavior.

During the past decade, there has been a decline in Texas teen pregnancy and birth rates. For instance, in 1991 the Texas teen pregnancy rate for girls ages 13-17 was 41.8 per 1,000 compared to 28.5 per 1,000 in 2002. This trend reflects a 31.8 % decrease in teen pregnancy for this age cohort, Texas teens ages 13-17 also reported a lower birth rate during the same time period. In 1991, the teen birth rated for this cohort was 32.4 per 1,000. A rate of 24.5 per 1,000 was reported during 2002, representing a 24.4 % decline in Texas teen birth rates. This is all the more significant when compared to the increasing birth rate among women of all ages in Texas for the same time period.

When Texas teen birth data are compared to national teen birth statistics, the decline in teen births is less significant across all teenage cohorts. Between 1991 and 2002, the Texas teen birth rate for girls ages 10 – 14 declined by 36.8% compared to 50% nationally. The Texas teen birth rate for girls' ages 15 –17 was 50.4 per 1,000 in 1991 compared to 38.2 per 1,000 in 2002. This represents a 24.2% decline in birth rates for 15 – 17 year olds. At the national level, teen girls ages 15 –17 reported a 39.9% decline in teen birth rates (38.6 per 1,000 in 1991; 23.2 per 1,000 in 2002). In addition, Texas teens

aged 18 –19 had a 8.7% decline in teen birth rates compared to a 22.6% decrease at the national level.

A Comparison of U.S. and Texas Teen Birth Rates, 1991 - 2002

Age Cohort	U.S. Birth Rate 1991	Texas Birth Rate 1991	U.S. Birth Rate 2002	Texas Birth Rate 2002	U.S. % Change	Texas % Change
10 - 14	1.4	1.9	0.7	1.2	-50	-36.8
15 - 17	38.6	50.4	23.2	38.2	-39.9	-24.2
18 - 19	94.0	112	72.8	102.3	-22.6	-8.7

HIV/STDs

In 2001, the Texas Adolescent Health Indicators for Youth ages 13-17 reported a total of 27,847 cases. Of those cases, 20,619 were chlamydia, 7,072 were gonorrhea and 156 were syphilis. In 2003, Texas HIV/STD data reported 198 cases of HIV and 28 cases of AIDS for youth between the ages of 10-19. Reported chlamydia cases in 2003 were 1,469, and 1,086 cases of gonorrhea.

Assessment of stakeholder input ***(perceived needs)*** for children and adolescents

The following summaries of the ***perceived needs*** were derived from stakeholder input for the children and adolescent population.

Summary of Attachment C – ***perceived needs*** from stakeholder input, Part II-b, children and adolescents

As for women and infants, an overwhelming number of stakeholder responses were related to infrastructure-building and population-based needs for children and adolescents. All needs were recognized as an overlapping concern for both the child and adolescent population; however, through further analysis of stakeholder input, age-group specific needs were identified. Most of the population-based service needs were related to teen pregnancy prevention for older children and to obesity prevention, injury prevention, and issues of well-checks, including oral health, for younger children. Most of the direct service needs noted by stakeholders were for older children in the areas of mental health and substance abuse. Stakeholders only noted a few direct and enabling service needs for younger children, and those included increased newborn screening and healthcare access. Infrastructure service needs noted frequently for all ages of children included nutrition and physical activity and policy development or changes that would improve access to medical homes for primary care, mental health, and oral health services. Suicide prevention was specifically noted for older children and access to Medicaid and CHIP were noted for younger children.

Suggested infrastructure-building activities pertaining to the early childhood population were the following:

- provision of community education and support for families to make informed decisions about social and emotional development of children,
- addressing child health and safety issues, and
- establishment of medical homes.

For the adolescent population, stakeholders suggested activities involving comprehensive services, which include mental health, screening and referral, dental health, and screening for high risk behaviors. Suggestions were also made to incorporate family and community (e.g., school districts) in providing such services. As noted, obesity was recognized as a prevalent issue for children by stakeholders. Some suggested activities included

- implementation of health curricula encompassing nutrition and physical activity within schools,
- family support to promote healthy eating habits, and
- grant funding to support efforts in local communities.

Most suggestions for children and adolescents included population based services and infrastructure-building such as partnerships with established networks, e.g., WIC and school districts.

Re-instatement of CHIP dental services was an activity resoundingly emphasized by stakeholders, and those services were reinstated in the 79th Texas Legislature. Activities to increase dental screening and treatment have been addressed in both the national and state activity plans. A feasible activity that was suggested was school-based dental clinics.

Overall, stakeholders expressed a high need for population and infrastructure-building services that will increase access to primary care, mental health and oral health and focus on prevention of obesity. If provided, these services would ultimately improve the overall health and well-being of children, leading to improvements in obesity and oral health. This input from stakeholders was strongly considered in determining ***critical needs*** that were later prioritized by stakeholders, as discussed in section II.B.5., Selection of State Priority Needs, and in the development of state activity plans that focus on infrastructure and population-based services.

<u>Summary of Attachment D – stakeholder input from Part III, NPM activities for children and adolescents</u>

Stakeholders suggested many valuable activities to address the performance measures on newborn screening, immunizations, oral health, teen pregnancy, children without CHIP or Medicaid, and adolescent suicide deaths. Stakeholder input related to newborn screening (NPM 1) included increasing training of personnel in handling newborn screens, shortening the length between the first and second screen to meet national standards, and to continue efforts currently in place. Therefore, the FY05 activities will be continued in FY06.

For improving oral health, stakeholders suggested educational programs within the school community to educate parents and children, the reinstatement of CHIP dental

services, and grant funding for school linked services. The feasible activities were integrated mostly into the state activity plan since the national activity plan is focused on dental sealants for 3rd graders.

Suggested activities to improve immunization rates (NPM 7) included

- public awareness campaigns and public education regarding the importance of immunizations,
- convenient immunization clinic locations and hours, and
- increasing community support of immunization efforts.

To that end, the Texas Immunization Stakeholder Working Group will continue with the infrastructure-building activity in FY06 to promote coalitions around the state for improving vaccine coverage.

Activities suggested for reduction of teen pregnancy (NPM 8) were risk reduction through educational programs such as abstinence and increased family planning services. The FY06 national activity plan includes the issuance of a competitive RFP to target areas of the state with the highest incidence of teen pregnancy to increase family planning to teens and to target Hispanic and African American disparities.

Increased public service announcements and education for parents and children were suggested activities for NPM 10, relating to the rate of deaths to children aged 14 and younger caused by motor vehicle crashes. FY06 activities related to the distribution of car safety seats and education of parents will continue to be provided to address this measure. These activities are the result of a collaboration between DSHS and the Texas Department of Transportation.

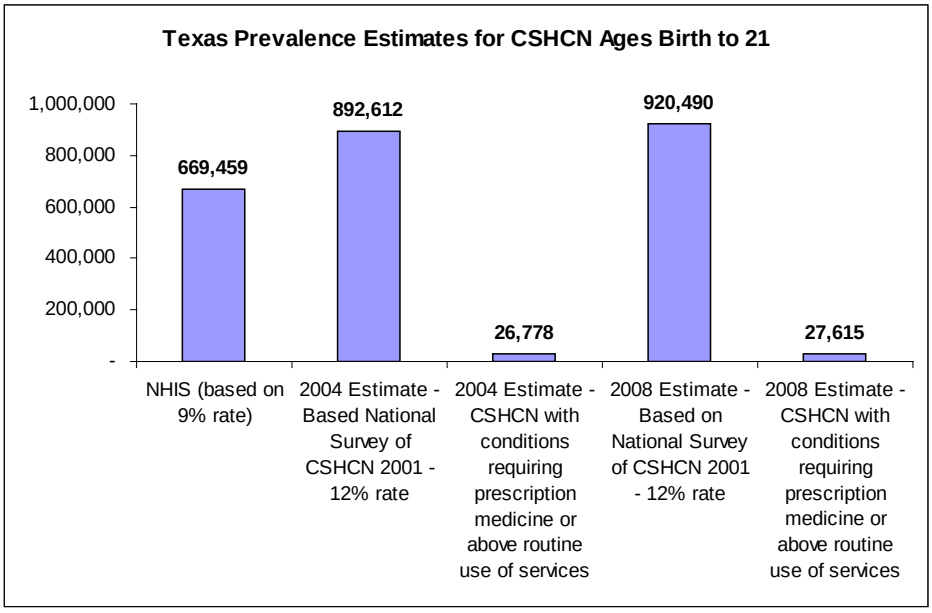
Stakeholder suggestions for newborn hearing screening (NPM 12) included activities that are currently being addressed by the Newborn Hearing Screening program at DSHS. The Texas program serves as national model for this mandated program.

Suggested activities regarding NPM 16 include increased funding for more and improved mental health services and integration of mental health services within schools. The creation of FY06 NPM activities focused on statewide infrastructure and community support for mental health services in order to decrease adolescent suicide rates.

After ***quantitative data needs*** were thoroughly reviewed and stakeholder input was analyzed, MCH subject matter experts then compared the ***qualitative data needs*** to the ***quantitative data needs*** to determine the ***critical needs*** for children and adolescents in Texas, and stakeholder input was requested for the second time to prioritize the critical needs in order to select final priorities for the state. A discussion of the critical needs and the results of the stakeholder prioritization (Attachments E and F) is in section II. B. 5., the Selection of Priority Needs.

Assessment of CSHCN Population

Table 1 provides information on prevalence estimates for children with special health care needs in Texas.



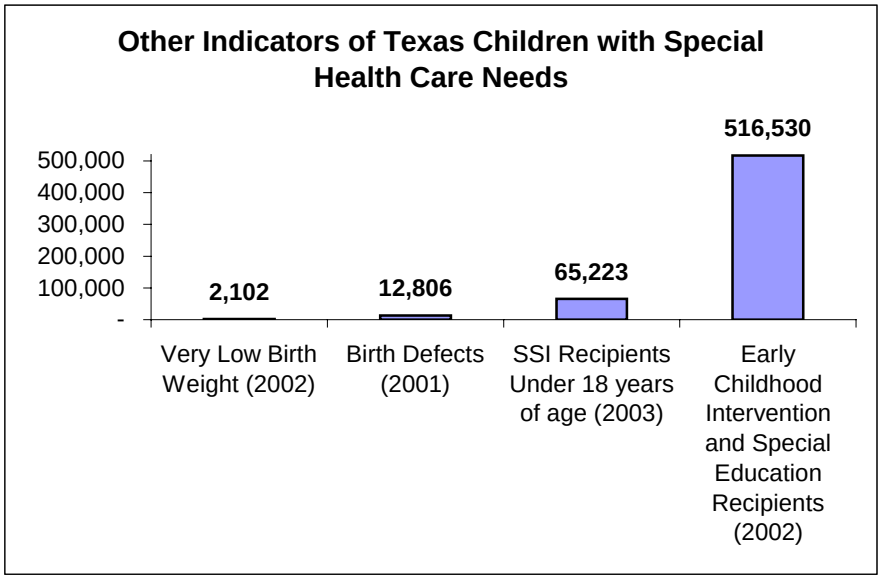
The number of children with special health care needs in Texas most likely has been underestimated. Table 1 provides an estimate of the number of children with special health care needs in Texas comparing previous, current, and future projections based on the following definition: "*Children with special health care needs are those children who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.*"[1]

Previous projections were based on results of the National Health Interview Survey (NHIS) applying a 9% prevalence estimate to the 1999 projected population of children ages birth to 21. According to the 2001 National Survey of Children with Special Health Care Needs, twelve percent (12%) of children in Texas from birth to 17 years of age have special health care needs.[2] This percentage translates to 730,437 children and youth with special health care needs according to 2004 Texas population data.[3] If the same percentage is applied to youth with special health care needs who are 18-21 years old, an additional 162,175 youth would be included, yielding a total of 892,612 from age birth to 21. As the overall population of Texas continues to grow, so will the number of CSHCN. By 2008, the number of CSHCN age birth to 17 is expected to be 752,255, and the total from birth to age 21 is expected to be 920,490.[4] Additionally, the Survey estimated that three percent (3%) of Texas CSHCN have conditions that require prescription medication

[1] Maternal and Children Health Bureau, Division of Services for Children with Special Health Care Needs. http://mchb.hrsa.gov/
[2] National Survey of Children with Special Health Care Needs, Maternal and Child Health Bureau, 2001. http://www.cshcndata.org/ Data Resource Center for Child and Adolescent Health
[3] Department of State Health Services, Research and Public Health Assessment Branch, September 2004.
[4] National Survey of Children with Special Health Care Needs, Maternal and Child Health Bureau, 2001.

and above routine use of medical, mental health, or other services. This percentage translates to approximately 26,778 CSHCN in 2004 and is expected to be 27,615 CSHCN by 2008.[5]

Table 2 provides information on other indicators of CSHCN in Texas.



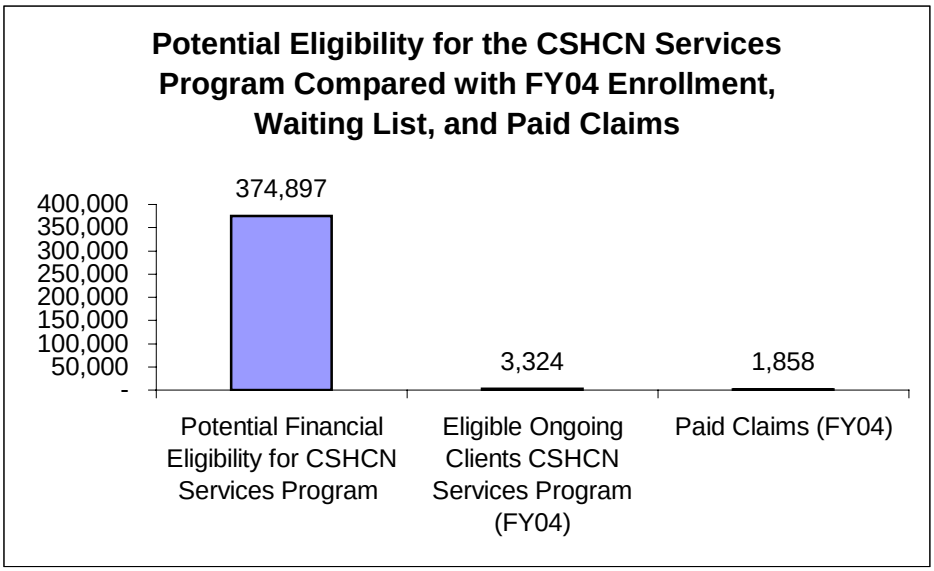
Birth Defects and Very Low Birth Weight - Infants born at very low birth weight (VLBW) are at higher risk for experiencing long-term developmental and neurological disabilities than are infants of normal birth weight. In 2002, 2,102 Texas infants (1.2% of all live births) were born at very low birth weight. In 2001, 12,806 cases of birth defects were detected among live born infants and fetuses of 20 or more weeks gestation in Texas. Higher incidence rates for Anencephaly, spina bifida, and ventricular septal defects were noted for Hispanics. Lower incidence rates for oral clefts and Down Syndrome were noted for African Americans.6

Children on Supplemental Security Income (SSI) - Another source of information used to identify the extent of the Texas CSHCN population is the number of children on Supplemental Security Income (SSI). In 2003, 65,223 children under 18 years of age were recipients of SSI.[7]

[5] Ibid.
[6] DSHS Center for Health Care Statistics, 2001-2002.
[7] Social Security Administration, 2003.

Early Childhood Intervention and Special Education - Another indicator to assess the extent of CSHCN populations is the number of children with disabilities receiving early childhood intervention services (ages birth to 3 years), and special education services (ages 3 to 21 years) under the Individuals with Disabilities Education Act (IDEA). The 2002 Child Count indicated that 20,296 infants and toddlers were receiving early childhood intervention services and 496,234 children were receiving special education services.[8]

Table 3 indicates potential eligibility for the CSHCN Services Program compared to CSHCN Services Program data on actual enrollment and paid claims.



CSHCN in Texas whose families' income is less than 200% of federal poverty level (FPL) and who meet medical and other criteria are eligible for the CSHCN Services Program. Approximately 42% of Texans have income that fall under 200% of FPL.[9] Based on this information, approximately 374,897 CSHCN might be potentially eligible for the CSHCN Services Program. Data indicates that the CSHCN Services Program (Health Care Benefits) is serving significantly fewer than the potentially eligible population. As of 8/31/04, there were 3,324 eligible ongoing clients in the CSHCN Services Program and an additional 395 clients were on the waiting list. Additionally in FY04, 4,400 CSHCN received family support services, such as information and referral, assistance in accessing community resources, respite, specialized child care, and equipment or supplies through DSHS contractors.[10] Case management services are

[8] IDEA Child Count, 2002.
[9] Kaiser Foundation Health Information – Distribution of Total Population by Federal Poverty Level, 2001-2002
[10] DSHS CSHCN Services Program Data, FY2004.

available through DSHS regional social work staff and contractors, regardless of eligibility for CSHCN Services Program Health Care Benefits. In FY04, more than 30,000 children received case management through DSHS regional social work staff and contractors.

Families with children who are eligible for the CSHCN Services Program must apply for Medicaid and Children's Health Insurance Program (CHIP) benefits. In FY04, about 35% of CSHCN eligible ongoing clients had Medicaid coverage all or part of the year. Approximately 12% were covered by the Children's Health Insurance Program (CHIP) and a smaller percentage (approximately, 6.3%) were covered by other private insurance). Nearly 47% of CSHCN enrolled clients had no other coverage. As of 8/31/04, the CSHCN Services Program had paid claims for 1,858 clients in FY04 (approximately 56% of eligible ongoing clients). [11]

CSHCN in Texas are racially and ethnically diverse, with 59.1% being White (non-Hispanic), 25% Hispanic, 12.2% Black, 2.2% multi-racial, and 1.4% other.[12] Texas population projections indicate that Texas' population will become less than one-half Anglo before 2010 and will become a majority Hispanic state between 2025 and 2035. Rapid growth is projected along the Texas-Mexico border.[13]

II.B.4. Examine MCH program Capacity by Pyramid Levels

Maternal and Child Health Population

a. & b. Direct Health Care and Enabling Services

The Texas Title V Program provides funds for the provision of direct, enabling, population-based and infrastructure building activities around preventive and primary care services for pregnant women, mothers, infants, children, and adolescents. The majority of MCH services are provided through contracts with local providers, including local health departments, city and county health departments, universities, medical schools, FQHCs, hospital districts, school districts, local coalitions, and individual providers. Title V-funded providers must be Medicaid providers. Contracts are awarded through a competitive request for proposal process. In areas of the state where no local contractors exist, MCH direct and enabling services are provided by DSHS public health regional offices through their clinic sites. MCH direct services are provided to women, infants, children, and adolescents who are at or below 185% FPL and not eligible for Medicaid and CHIP. Title V-funded providers are required to screen for Medicaid/CHIP eligibility and to assist those individuals who are potentially eligible for Medicaid or CHIP with the application forms. Title V program is the payer of last resort after private insurance, Medicaid, and CHIP. Otherwise, these populations would typically access health care services through costly emergency room use, funded primarily with state and local tax dollars.

[11] DSHS CSHCN Services Program Data, FY2004.
[12] National Survey of Children with Special Health Care Needs, Maternal and Child Health Bureau, 2001.
[13] "The Texas Challenge in the Twenty-First Century: Implications of Population Change for the Future of Texas," Texas State Data Center, 2004. http://txsdc.utsa.edu/pubsrep/pubs/txchal.php

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 provide 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 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.

Access to Care for Title V Populations:
In general, health care access for women and children in Texas has improved significantly since 1989. First, major Medicaid expansions have occurred, including expansion of Texas Health Steps (THSteps--formerly EPSDT), expansion of Medicaid eligibility to pregnant women, infants, and children, and the growth of Medicaid managed care. Another trend involves the evolution of the Title V Maternal and Child Health Block Grant program at both the state and federal level. In spite of major improvements, there are still significant gaps and barriers to health care access.

Population-in-need and Title V eligible clients served: The total population-in-need for Title V services excluding Medicaid eligible clients is estimated to be 2.8 million. Of this, Title V estimates that about 1.4 million or 50% are women and adolescents, potentially in need of publicly-funded family planning services and the remaining 50% are children ages 0-21 in need of child health services at 185% of FPL. Client data from Title V-funded contractors show that only 73,875 women and adolescents received family planning services in FY 2004, representing 5% of the population-in-need for family planning services in Texas. In addition, client data indicate that Title V child health clinics provided preventive and comprehensive care to approximately 43,417 unduplicated clients ages 0-21 in FY 2004, representing 3% of the children-in-need.

Unemployment, Income, and Poverty: Data indicate that Texas unemployment, as in the rest of the nation, remains at an all time low and Texas statewide unemployment was 6.1 in February, 2005. While the overall unemployment rate is relatively low, there is a great deal of variation between regions of the state. The four Standard Metropolitan Statistical Areas (SMSAs) in the central Texas area (Austin-Round Rock, Bryan-College Station, Waco, Killeen-Temple-Fort Hood) had the lowest unemployment rate. In contrast, the Rio Grande Valley (Laredo, Brownsville, Harlingen, Edinburg, Mission, McAllen),

predominantly Hispanic, had the highest unemployment rate in Texas (see Attachment A1). In 1999, Texas' statewide average income per capita was $19,617. Counties along the Texas-Mexico border area had the lowest income at less than $15,000 (see Attachment A1). As a result of the lowest income and highest unemployment rates, a large concentration of the population living at or below FPL was along the Texas-Mexico border area. Furthermore, Hispanic and African American groups continue to represent a disproportionate number of those Texans living under poverty conditions.

Childhood Poverty: In 2005, there were approximately 6.5 million children age 18 and under in Texas. They constituted 29% of the state's population. In 2040, they will represent 22% of the population, which will translate to 7.8 million children. The defining feature of the children's population in Texas is the number of children living in poverty. The rate of poverty for children in Texas is higher than the national average. In 2003, 20% of all Texas children, compared to 18% for the U.S., were classified as living in poverty. Data also indicate that there are disproportionate poverty rates among children. The poverty rates among African American and Hispanic children statewide are much greater than White children.

Lack of Health Insurance Among Children: More than 1 million, or 20%, of the population ages 0-18 years in Texas were uninsured in 2003. Lack of health insurance coverage is one of the greatest barriers to children accessing health care in Texas and the subsequent lack of proper medical care for children can have serious economic repercussions for Texas. Attachment A1 reveals that 30% or more of children ages 0-18 without health insurance are clustered along the Texas-Mexico border area.

Border Health: While the border region is a dynamic part of this state and nation both in population and economic growth, it is characterized by high poverty and disease rates. Approximately, 2 million Texans live on the Texas-Mexico border, with an estimated 400,000 border residents living in about 1,400 colonias that are predominantly Hispanic, sometimes lacking basic services such as water and wastewater. Of these 2 million, 36% live in poverty, as compared to 17% among non-border residents. More than one of every three border county residents has no health insurance and is not covered by Medicaid or Medicare.

Primary Care Physician: In 2004, there were 34,904 direct patient care physicians (DPC) in Texas. This number excluded 3,700 federal and resident-fellow physicians. The total direct-patient-care physician supply in Texas has increased by an average of 1,000 physicians per year between 1995 and 2004. Since the state's population also has increased during this time, the supply of primary care physicians was about 137 to 155 primary care physicians per 100,000 population from 1995 to 2004. Twenty-two of the state's 254 counties had no primary care physicians as of September 2004, and 18 counties had at least one practitioner. The number of DPC physicians was lowest in non-metropolitan border areas at 71 per 100,000 population and highest in metropolitan non-border areas at 171 per 100,000 population. A decrease in the number of DPC physician between 1995-2004 was observed in 44 counties. For the 130 counties designated as

whole county Health Professional Shortage Areas (HPSAs), the number of DPC physicians was 67 per 100,000 population.

In 2005, the projected population for Texas was 25.5 million. Twelve percent of this population was located in 177 non-metropolitan or rural counties and 88% was located in 77 metropolitan or urban counties. In comparison, 10% of practicing primary care physicians were located in rural areas of the state, and 90% practiced in metropolitan counties. Recruiting and retaining physicians in rural counties can be both challenging and frustrating. Because physicians' salaries in rural areas are often lower with a potentially higher work load than in urban areas, and fewer educational opportunities exist in rural areas, incentives (such as federal and state loan repayment programs) help to attract physicians into rural practice.

The Title V CSHCN program relies on specialists as well as primary care physicians. In the area of pediatrics, there were 3,019 licensed pediatricians in Texas in 2004, and 119 counties do not have a pediatrician. Statewide, there were a total of 81 pediatric cardiologists; 17 pediatric endocrinologists, 50 pediatric surgeons; and 51 pediatricians with a specialty in hematology/oncology**.** Pediatric surgeons, cardiologists and oncologists are found in 13, and pediatric endocrinologist in nine of the 254 Texas counties.

Many CSHCN also require occupational therapy, physical therapy, and nutritional services. Recent data (2004) indicate shortages in a number of areas

- There were 5,173 occupational therapists and 99 counties had no therapists.
- There were 8,245physical therapists and 61 counties had no physical therapists.
- There were 3,150 registered dietitians and 97 counties had no dietitians.

Other Shortage Areas: In 2004, there were 74 counties in Texas with no hospitals. Counties with a hospital but reporting no obstetrical service numbered 60. There were 54 counties with no physician assistants; 47 counties without a dentist; 74 counties without nurse practitioners; 52 counties with no licensed social workers; and 219 counties with no nurse midwives.

Health Professional Shortage Areas: The combined diversity of Texas' demography and geography challenges all residents in adequate access to health services. For several years, Texas has led the nation in the number of primary care physician shortage areas. In 2004, 130, or close to 51%, of the 254 counties were recognized as having too few primary care physicians including family practitioners, general practitioners, pediatricians, internists or obstetrician/gynecologists. Attachment A-1 shows the Federally Designated Primary Health Professional Shortage Areas in Texas. Shortages were found for the entire geographic area of 130 counties. More than 3 million, or15%, Texans reside in physician shortage areas. Two-thirds of Texas shortage areas have high proportions of minority populations. Of the total population living in the 130 county area, more than half are predominantly Hispanic, with the largest concentrations along the border and in South Texas.

Focusing on these areas, many of the 130 shortage areas have less than seven residents per square mile. These sparsely populated areas experience additional challenges in recruiting and retaining health professionals. Furthermore, supply shortages are not limited to rural areas. Some inner-city areas are federally recognized as experiencing access barriers to primary care providers. Although the number of providers appears adequate in these areas, access is limited based on non-acceptance of Medicaid or patient's inability to pay for services. This demonstrates that the presence of providers does not necessarily equate to access for all residents.

Rural Health: With 70% of Texas counties designated as rural, access to primary and preventive health care services for about 3.1 million rural residents remains at risk. One hundred and four counties (59%) of the state's 177 rural counties are designated Primary Care Health professional Shortage Areas (HPSAs). Because of the lack of available primary care providers, such care is often delivered ineffectively and inefficiently. Hospital emergency rooms often become clinics, a costly way to provide basic care. Without available primary care, rural residents lack an appropriate entry into the health care systems. No financing, managed care or other access scheme can operate effectively without this groundwork.

The barriers to access to care described above contribute to women not accessing prenatal care in a timely manner, not remaining in care for the duration of the pregnancy or missing appointments due to reluctance to travel long distances or pay for services. Postpartum and inter-conception visits may also be delayed or skipped. After infants are born, well baby checks and immunization visits may be missed or delayed, as may preventative and therapeutic dental health visits for women and children. When these visits are missed, there are fewer opportunities to observe developmental delays or health concerns that can ultimately lead to long-term problems. Mental health issues might also not be identified. Women who are experiencing problems might avoid addressing them, and providers have fewer opportunities to observe warning signs. Even if a provider does observe symptoms, there is often a dearth of mental health providers to serve the population. Due to the lack of providers in Texas, Title V is involved in an on-going effort to explore training primary health care providers to screen, identify and provide basic treatment for some behavioral disorders including mental health and substance abuse.

c. Population-based Services

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 in the following areas: motor vehicle deaths among children, child abuse/neglect, SIDS, child obesity, infant mortality, low birth weight births, teen pregnancy, prenatal care, adequacy of prenatal care, and STDs.

As the Title V Population-Based program heads into a new funding cycle starting January 2006, Title V staff are currently evaluating how current population-based fund dollars are used and how they might be best used to achieve maximum impact. Future population-based projects may include funding specific and prescriptive population-based activities and evidence-based interventions addressing the Title V FY 06 priority needs and national and state performance measure targets in demonstrated need areas.

The second category includes a variety of population-based programs and initiatives with a statewide impact, delivered by DSHS central and regional offices. The following is a high level summary of population-based programs funded by Title V program:

Health Screening Programs

The Title V health screening programs at DSHS include newborn screening for hearing loss, congenital and heritable disorders. Additionally, older children in day cares and schools are screened for vision, hearing and spinal conditions. Approximately 375,000 children are born in Texas annually. Texas screens approximately 96% of all newborns for 5 metabolic disorders (phenylketonuria –PKU-, galactosemia, congenital hypothyroidism, sickle hemoglobinopathies, and congenital adrenal hyperplasis) and 98% of all newborns for hearing loss. In 2004, Texas followed up on over 10,000 abnormal metabolic screens and referred about 5% of all children for follow up hearing tests. In the older child population, approximately 5 million children were screened for vision and hearing and of those about 300,000 were referred for follow up. In the spinal screening program, approximately 600,000 children were screened and 16,000 were referred for follow up. DSHS staff members develop rules, standards, and training, and provide oversight and monitoring of the various health screening programs. DSHS is a lead agency for the Early Hearing Detection and Intervention (EHDI) process. Texas EHDI (TEHDI) is working across agencies to utilize the regional infrastructure in place for Early Childhood Intervention (ECI), Deaf and Hard of Hearing Services, and Texas Education Agency (TEA) Regional Day School Programs for Deaf and has formalized an interagency collaboration through the Texas EHDI Coalition. All of the health-screening programs work closely with case management. The newborn hearing program works with case management staff to assist Spanish-speaking families who need access to services. Regional case management staff assist newborn screening in locating children with abnormal screens to ensure necessary confirmatory testing and follow up occurs. Children with abnormal screens in the various programs are referred to case managers who then assist in connecting the families to local resources. Regional case managers coordinate at the local level with multiple agencies to coordinate services and share resources. Specific emphasis on enhancing coordination with the Department of Family and Protective Services (DFPS) is a current priority to ensure that the population served by DFPS is accessing needed health care services. Additionally, regional staff are regular participants in case management coalitions, community resource coordination groups and

child mental health teams. National trends in the expansion of the newborn screening panel are being addressed in Texas. Recent legislation and funding requests will result in an expansion in the number of disorders screened in Texas and a comprehensive look at the infrastructure that exists to serve newly identified children that will need confirmatory testing and follow up care. Changes in the technology that is utilized in newborn screening laboratory test will allow many more conditions to be identified at or shortly after birth. The laboratory and newborn screening areas work closely together to coordinate services; everything from the identifying the children with abnormal screens, educating providers and ensuring appropriate follow up occurs.

School Health

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 TDH 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.

Women's Health Initiatives

Staff members from the Title V Women's Health Area and the Nutrition Services Section continue to work collaboratively to support the Texas breastfeeding initiative activities. Multiple strategies are used to promote breastfeeding across the state. The initiative has provided breastfeeding promotion materials and services through WIC clinics, Title V-funded providers, local health departments, hospitals, physicians' offices, private non-profit agencies, community health centers, home health nurses, and peer counselors. The Texas Ten Steps Hospital Program has been actively promoted to encourage hospitals to implement the Ten Steps to Successful Breastfeeding to help new mothers get off to a good start in the hospital. Staff members also use Breastfeeding Promotion and Support Training Programs to provide necessary information to health care providers in order to support mothers both in deciding to breastfeed and in continuing to breastfeed throughout the first year or longer.

Efforts are being made to establish regional perinatal health systems to improve perinatal health and birth outcomes throughout the state. DSHS has convened ad hoc workgroups to obtain stakeholder and public input in implementing the regional perinatal systems legislation and to identify priority perinatal projects. In the last year, workgroups have supported the implementation of the Pregnancy Risk Assessment Monitoring Surveillance (PRAMS) system in Texas and assisted in working with each public health region to identify current perinatal systems resources and possible gaps in services. Title

V staff members are working with DSHS public health regional staff to provide local health data and information to support the regional staff in assessing and developing local perinatal health system.

Oral Health and Community Water Fluoridation

The essential functions of the Department of State Health Services (DSHS) Oral Health Group (OHG) are to provide statewide leadership in oral health assessment, policy development and assurance. Assessment is being accomplished through the use of the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey (BSS). Statewide-targeted populations for the BSS are third graders in public schools and children enrolled in Early Head Start and Head Start (EHS/HS) programs. Policy development activities are currently directed primarily towards dental policies associated with the Texas Health Steps (THSteps) Dental Services, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program in Texas. The assurance function of the DSHS OHG is being addressed through the school-based dental sealant and the EHS/HS/Women, Infants, and Children (WIC) preventive dental services projects that are in process at this time. The EHS/HS/WIC preventive dental services include the provision of an oral examination, dental prophylaxis, topical fluoride application, and targeted referrals for therapeutic dental services in the EHS/HS population as well as pregnant women on Medicaid and their children who participate in the WIC program.

DSHS OHG has six staff members including the State Dental Director. There are also five regional dental teams, headquartered throughout the state, comprised of a dentist and dental hygienist. As the school-based dental sealant and EHS/HS/WIC preventive dental service projects are expanded beyond the scope of existing staff, additional dental hygiene professionals will be needed for the provision of services in an efficient and effect manner. The OHG Central Office (CO) staff members provide professional and programmatic guidance to the regional dental teams, including the preparation of grant applications and required semi-annual and annual grant reports, surveillance data entry, and program activity promotion. The OHG regional teams provide direct dental preventive services to the targeted populations including the obtaining of surveillance data. Both the CO and regional dental team members interact with internal and external stakeholders to identify areas of oral health needs and the allocation of collaborative resources in order to best meet those needs. Through these collaborative arrangements, oral health activities across the state are coordinated and provided in a consistent manner.

The DSHS OHG, through the leveraging of state general revenue and grant funding from the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA), continues to enhance the oral health infrastructure leadership, the school-based dental sealant projects, and initiate the EHS/HS/WIC preventive dental services project. CDC funding has been directed towards the development of a statewide oral health surveillance system, the Texas Oral Health Coalition, and *Oral Health in Texas* that reports on the dental disease burden in Texas. The HRSA grant has provided funding for new, state-of-the-art portable dental equipment and dental supplies for the provision of early preventive dental services in the EHS/HS/WIC target populations. These activities support the primary goals of building

the state oral health infrastructure, developing/enhancing an oral disease surveillance system, mobilizing support for oral health, building collaborative partnerships to implement population-based oral health programs, and building collaborative partnerships to implement strategies to increase access to and quality of the oral health care system as outlined in the *Collaborative Oral Health Plan in Texas, January 2005,* Department of Community Dentistry at the University of Texas Health Sciences Center Dental School, San Antonio.

In addition, the Texas Fluoridation program continues to increase the percentage of the population that receives the life long oral health benefits provided by the consumption of optimally fluoridated water through site inspections of community water systems, operator training, fluoridation quality monitoring and system design. In FY 05, 168 water works operators from 32 water systems were trained in the skills needed to operate fluoridation facilities in public water systems. The operators receive eight hours of certification credit for their participation in the class. Topics covered include the oral health benefits of fluoridation, chemical calculations, metering pump calibration, chemical handling safety and fluoride testing.

In order to realize the essential functions of OHG as well as the vision of improving the oral health of the citizens of Texas, the collaborative efforts that have occurred through the EHS/HS/WIC preventive dental services project, the school-based dental sealant projects, and the Texas Oral Health Coalition, will continue to be important avenues toward the realization of a sustainable, replicable, and enhanced oral health program in Texas. Due to the recently completed 79th Legislative Regular Session, dental services are restored in CHIP with a starting date for services December 1, 2005 and this will drastically improve access to oral health.

d. Infrastructure-building Services

Title V program provides MCH services primarily through contracts with local providers. In FY 2004, a total of about $30 million has been contracted out for the provision of direct and enabling services (prenatal care, family planning, child health, dental for children, case management, genetics, etc.) and population-based/infrastructure-building projects. Many of the MCH contractors are also WIC, Family Planning (Titles X, XX, and XIX), Medicaid (prenatal care, case management for high-risk pregnant women and infants), Texas Health Steps (EPSDT), Primary Health Care, Breast and Cervical Cancer Control Program and/or HIV/STD providers and, as such, are able to provide improved access to a more comprehensive array of services to women and children and families.

The Preventive and Primary Care Unit of the Family and Community Health Services (FCHS) Division guides the development of clinical policies and operational processes that assist contractors in the delivery of clinical services. Dr. Janet Lawson is DSHS's only board-certified Obstetrician/Gynecologist and provides leadership and consultation in the development and clarification of clinical policies and protocols for community

health services programs (CHS). CHS staff members maintain expertise in national health standards and guidelines and provide clinical and technical support services to contractors. Professional education opportunities for clinical and administrative contractor staff are developed and implemented 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.

The Performance Management Unit located in FCHS 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. The Quality Management Branch 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 these are reviewed with other CMS 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.

The Department of State Health Services (DSHS) and Title V program operate within a structure defined by 11 health service regions (HSRs) 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 (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 (SLA) 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 HSR and provides quantifiable time-specific performance measures, activities, and outcomes that each Title V-funded HSR agrees to complete during specified timelines. Title V central and regional staff will be working together to develop and finalize the SLAs.

In addition, the Research and Public Health Assessment (R&PHA) Office serves to ensure the science-based foundation of FCHS Division business by providing MCH epidemiology support. R&PHA aggregates contractors' client data and supports Title V-funded contractors by developing annual fact sheets, including demographics and selected health status indicators, at the county/city level for needs assessment purposes, and responding to specific data requests from the contractors. R&PHA administers PRAMS, which enables Title V programs and its contractors to gain a better understanding of how specific risk factors impact health outcomes.

An important aspect of capacity in Texas is the availability of and access to preventive and primary health services. In 2003, the 78th Texas Legislature appropriated $10 million for the 2004-2005 biennium for the implementation of the FQHC Incubator Grant Initiative to provide grant funds to help organizations expand and develop FQHCs and FQHC Look Alikes. In FY 04, DSHS implemented the FQHC Incubator Grant Program. This grant-focused program made grants through a competitive process to establish new or expand existing facilities that can qualify as FQHCs. Each successful grant applicant enters into a contract with DSHS that specifies a schedule of payments and the benchmarks they must achieve for continued funding at each stage. The Texas Primary Care Office (TPCO), under the supervision of the State Title V Director, provides technical assistance and grant administration relative to this initiative. To date, more than 20 organizations received an FQHC designation or FQHC Look Alike certification. Because of the success achieved through this initiative, the recently completed 79th Texas Legislature appropriated level funding to continue the initiative efforts for the 2005-2006 Biennium. In addition, TPCO administers the J-1 Visa Waiver to allow DSHS to request waiver of the foreign country residence for a qualified physician to practice in a medically underserved or health professional shortage area designated by Department of Health and Human Services, that has a current shortage of physicians. In both 2003 and 2004, the number of applications received outnumbered the slots available and 60 waivers were submitted to the U.S. Department of State for approval. Both of these initiatives, the FQHC Incubator Initiative and the J-I Visa Waiver Initiative are under the oversight of the State Title V Director. This will provide additional opportunities for improving access to low-income families in medically underserved areas.

The Primary Health Care program, like the Title V program, provides primary care services to individuals at or below 150% of FPL through contracts to local providers. An integrated approach for the service delivery between the two programs is very critical to increasing the number of providers and counties served.

Service Delivery Initiative (SDI) 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 funding sources (Title V, primary health care, TB, Title X and XX family planning) are currently participating in the SDI pilot project using an automated system. SDI Integrated Eligibility, Billing and Reporting System (SIEBRS) is an internet-based computer application to automate screening, enrollment, billing, and reporting for multiple programs. During FY 2006, more Title V-funded contractors will be phased into the SDI environment. This will provide better monitoring of Title V-funded contractors' performance.

CSHCN population

Development of Systems of Care

As part of the reorganization of the Department of State Health Services (DSHS), beginning 9/1/04, the CSHCN Services Program and the Kidney Health Care Program

combined administrative functions under the Purchased Health Services Unit. Work will continue through FY2005 to more fully integrate these two programs within the Unit.

The CSHCN Services Program is an active participant in ongoing collaborative work with other state agencies and private organizations and consumers to address systems capacity, including the Children's Policy Council, Texas Council for Developmental Disabilities, Medical Home Workgroup, Texas Interagency Council on Early Childhood Intervention, Interagency Council on Autism and Pervasive Developmental Disorders, Promoting Independence, Traumatic Brain Injury Advisory Committee, Texas Integrated Funding Initiative (TIFI) Consortium, Community Resource Coordination Groups (CRCG), and the Governor's Committee on Persons with Disabilities.

Case management and care coordination services are available to help families to access necessary services. Case management and care coordination may be provided by staff in the DSHS regional offices throughout the state and Medicaid contracted case management providers.

Additionally, the CSHCN Services Program provides funding for community-based services through local contractors. Contracted services reach additional families throughout Texas and include case management and community and family support services, such as respite, service coordination, and wellness programs. A key purpose is to provide and promote family-centered, community-based, culturally competent, coordinated care, including care coordination services for CSHCN. The regional and contractual service providers also facilitate the development of new services for CSHCN, thus enlarging the available systems of care for CSHCN and their families. The CSHCN Services Program staff provide policy and contract administration for case management and other CSHCN contracts.

Under program rules implemented in 2004, family support services are provided as part of the CSHCN Service Program's health care benefits package. Due to budget constraints, family support services are limited in scope and amount. When the CSHCN Services Program has a waiting list for healthcare benefits, family support services can be provided only when they will help prevent an out-of-home placement or when the provision of the family support services is cost effective for the CSHCN Services Program. The CSHCN Services Program continues to have a waiting list for health care benefits, therefore, family support services continue to be limited and provided only under the previously stated situations.

The majority of CSHCN services are provided through individually enrolled providers across the state. These providers include, but are not limited to physicians, dentists, hospitals, outpatient hospitals, occupational therapists, physical therapists, speech-language therapists, home health agencies, pharmacies, laboratories, orthotists, prosthetists, and a number of other specialty care providers. Stakeholder feedback indicated concerns regarding state level capacity and access to heath care providers enrolled in the CSHCN Services Program and the Medicaid and CHIP programs, such as pediatricians, family practitioners, nurse practitioners, sub-specialist physicians, dentists

and orthodontists, and home health providers. Feedback indicated that there seemed to be limited numbers of health care providers for some services, especially in rural areas. Stakeholder feedback noted that challenges to an adequate state level capacity of health care providers for CSHCN include a lack of financial incentives (low reimbursement rates and other billing issues), large rural areas, and provider enrollment procedures. Transportation is a critical need for families of CSHCN who must travel distances to receive health care.

Culturally Competent Care

The CSHCN Services Program proactively works to ensure cultural competence. Employees who are bilingual in English/Spanish staff toll-free information lines. The program's written communication with its clientele is available in Spanish and English. Many educational materials are also available in Spanish. Regional case management staff link with local refugee service programs for assistance and information. Texas Medicaid and Healthcare Partnership (TMHP) is the contracted claims administrator for the CSHCN Services Program, and Medicaid. The TMHP client services line has the capability of responding to inquiries from clients speaking English, Spanish, Vietnamese, or Chinese.

Family Partnership, Decision-making, and Satisfaction

Until 9/1/03, the CSHCN Services Program relied on its advisory committee for input to policy development. With the implementation of House Bill 2292, 78th Legislature, Regular Session, the CSHCN Advisory Committee no longer exists. The CSHCN Services Program developed alternative methods to gather information on the involvement of families and other stakeholders in the decision-making process. In FY04, Stakeholder Meeting Records (SMRs) indicated that a total of 370 consumers participated in 100 meetings reported on by CSHCN staff and contractors. Meetings covered a wide range of topics including: Texas' reorganization of health and human service agencies under House Bill 2292, 78th Legislature, Regular Session; Medicaid and CHIP rules changes; Medicaid waiver programs; Medicaid managed care expansion; elimination of the Primary Care Case Management model for Medicaid; medical care for CSHCN in foster homes; Medicaid preferred drug and prior authorization; mental health benefits for children; access to services; community assessment; the need for respite care; transition to adult services; permanency planning; and the CSHCN Services Program waiting list.

The need for family input is also recognized by the state's Children's Policy Council. In its recent report to the Texas Legislature, the Children's Policy Council recommended that: 1) the Advisory Council for each Health and Human Services agency have at least one family member of a child receiving the agency's services; 2) family members be involved with workgroups and task forces developing policy and designing services; and

3) focus groups, town-hall meetings, and other means be used to obtain family and consumer input at the local, regional, and state levels.[14]

In a 2002 survey of families with children enrolled in the CSHCN Services Program conducted by the Department of State Health Services (then the Texas Department of Health), nearly 70% of survey respondents indicated that they were "Very Satisfied" with services received through the program.[15]

According to the National Survey of Children with Special Health Care Needs 2001, only 31% of Texas families of children whose special health care needs are above routine or have higher needs for services indicated that the measure related to family partnership in decision-making and satisfaction with services measure was achieved. Families of children whose special health care needs are managed only by prescription medicine are more likely to report achievement for this measure (approximately 77%).[16]

The Texas Center for Disability Studies held 11 focus forums in Fall 2004. Approximately 112 parents of young children participated in these forums and shared information on their experiences in accessing a variety of services from public agencies. Focus forum results noted four primary recurring themes:

1. Respect - Parents indicated that they do not feel respected by staff when they are applying for services from various agencies and programs.
2. Communication and Information Sharing - A lack of or overloaded case management systems and high staff turnover were noted to contribute to difficulties in communication and information sharing.
3. Issues with Services and Service Delivery - Focus forum participants noted dissatisfaction with many state agency systems with rigid eligibility or other criteria, long waiting lists, complicated application processes, and an overall lack of services for children who are undocumented
4. Access to Medical Care - Focus forum participants noted challenges related to accessing medical care related to transportation difficulties and limited availability of doctors and dentists.

Comprehensive Health Care Through a Medical Home

The American Academy of Pediatrics (AAP) detailed an operational definition of the medical home noting, "the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective." Medical care should be delivered or directed by well-trained physicians who provide primary care and help to facilitate a range of pediatric supports and services. The physician, child, and family develop a partnership of mutual responsibility and trust in defining and implementing a plan of care. This partnership respects the family's diversity and recognizes that they are the constant in

[14] "Making Children a Priority," Children's Policy Council Report to the Legislature, September 1, 2004, pages 10, 29.
[15] DSHS - CSHCN Survey of Client/Family Stakeholders, Spring 2002.
[16] National Survey of Children with Special Health Care Needs, Maternal and Child Health Bureau, 2001.

their child's life. The physician shares clear and unbiased information with the family about the child's medical care and community services and organizations. Transitions, including those to other pediatric providers or to the adult health care system, are planned and organized with the child and family. Care coordination among medical, educational, and other community services ensures that the special needs of the child and family are addressed.[17]

National health findings indicate that CSHCN with a medical home are approximately half as likely to experience delayed or forgone care, less than half as likely to have unmet health care needs, and less than a third as likely to have unmet needs for family support.[18]

Approximately 42% of Texas respondents to the National Survey of Children with Special Health Care Needs 2001 indicated that their child/children with special health care needs did not have a medical home (regular source of care).[19] At this time, there is not a common definition of "Medical Home" and the concept is not well understood by families or health care providers. Data is not available regarding the number of families whose children with special health care needs receive care through health care practices that incorporate all of the critical elements comprising a Medical Home, as defined by the American Academy of Pediatrics.[20]

In follow-up to the Texas Medical Home Training Conference held in October 2003, a Medical Home Workgroup (MHWG) was developed with members drawn from the conference and pre-conference, related programs including the Healthy Child Care Texas Grant and State Early Childhood Coordination Planning Grant, other agencies and organizations, and individuals concerned about children with special health care needs. Since January 2004, the MHWG has developed its mission and vision statements and a strategic plan for promoting medical homes for all children in Texas, including children with special health care needs. The MHWG was formed to raise awareness of providers and families of the importance of having a medical home for health care delivery and to increase the availability of medical homes for all children throughout Texas. Additionally, the MHWG recognizes the importance of a medical home in Medicaid Managed Care services and is exploring ways to partner with agency staff responsible for the expansion of Medicaid Managed Care and representatives of managed care providers.

The CSHCN Services Program helps promote the concept of a medical home for children with special health care needs through newsletters, publications, presentations, and training materials.

Additional significant challenges exist regarding the provision of medical homes for all CSHCN in Texas, including a lack of mechanisms for adequate third party reimbursement and effective continuity of health care for children in the foster care system.

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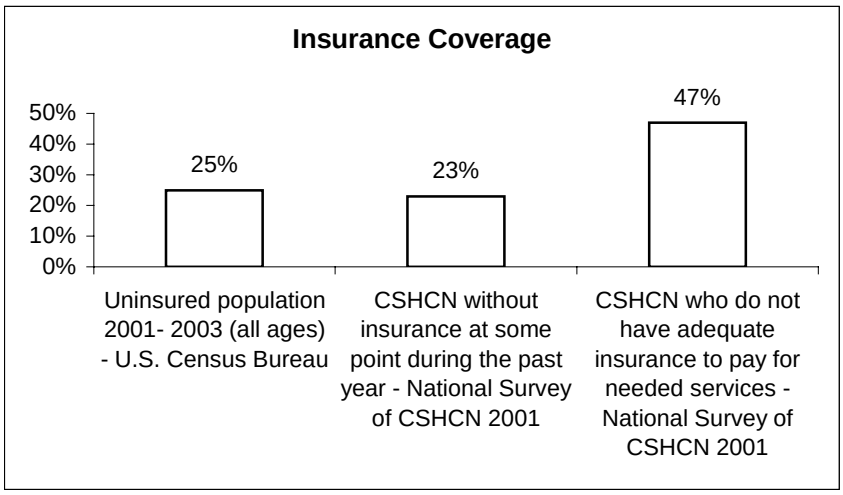
[17] Policy Statement – The Medical Home. Pediatrics Vol. 113 No. 5, May 2004.
[18] National Survey of Children with Special Health Care Needs, Maternal and Child Health Bureau, 2001.
[19] Ibid.
[20] The Medical Home. PEDIATRICS Vol. 110 No. 1 July 2002, pp. 184-186

The Health and Human Services Commission's Office of Early Childhood Coordination commissioned a survey of professionals serving in early care and education and health care arenas. The Texas Center for Disability Studies conducted the survey in Fall 2004. Respondents seemed most familiar with the early care and education arena. Survey results indicated that systemic issues generally were the lowest rated items, noting inadequate funding, inadequate staffing, non-supportive legislative policy, and a lack of knowledge by policy and decision-makers. Service delivery issues were generally the highest rated items, noting services rated as effective, based on best practices, delivered by well-trained staff, and coordinated. Professionals responding to the survey generally viewed health care services as being less family-centered than early care or educational services.

Adequate Insurance

Table 4 represents information regarding insurance coverage for Texas CSHCN.



In a Census Bureau comparison of all states, Texas had the highest proportion (24.9%) of uninsured population (all ages) over a three-year period (2001-2003).[21] Based on findings from the National Survey of Children with Special Health Care Needs 2001, twenty-three percent (23%) of Texas families with CSHCN (ages birth to 17) were without insurance at some point during the past year as compared to 12% nationally. Survey results noted that forty-seven percent (47%) of families with CSHCN in Texas did not have adequate insurance to pay for the services they need as compared to 40.4% nationally. Hispanic families with CSHCN were much more likely to not have adequate insurance to pay for the services they need (62.6%). Survey results also noted that CSHCN ages 6-11 were most likely to be uninsured at some point during the past year (24.5%). Hispanic and Black CSHCN were much more likely to be uninsured at some point during the past year (33.6% and 32.4% respectively) as compared with White

[21] Carmen DeNavas-Walt, Bernadette D. Proctor, Robert J. Mills, "Income, Poverty, and Health Insurance Coverage in the U.S., 2003," U.S. Census Bureau, Issued August 2004.
http://www.census.gov/hhes/www/hlthins.html

CSHCN (17%). CSHCN in families with incomes from 0-99% of the federal poverty level (FPL) and 100-199% FPL were much more likely to be uninsured at some point during the past year (43.1% and 44.3% respectively).[22]

The 78th Texas Legislature, Regular Session designated new eligibility requirements and reduced benefits for FY04 and FY05 to decrease overall Medicaid and CHIP spending. Continuous coverage periods were reduced from 12 months to 6 months for the Medicaid, CHIP, and CSHCN Services Program. Overall enrollment in CHIP decreased 29% when comparing September 2003 enrollment with August 2004 enrollment figures. Data indicated that fewer children were being enrolled in CHIP and more enrolled children were being disenrolled. Decline may be related to failure to renew, reduced rates of new applications, and the exclusion of income disregards.[23]

CSHCN Services Program staff continue to be actively involved in the development of a model for services to children with special health care needs in a managed care setting. Program staff provide feedback and expertise on language specific to the CSHCN population in managed care Request for Proposals (RFPs) and contracts and regional staff participate on advisory committees for Medicaid Managed Care and CHIP.

Easy Access to Services

Community-based services for CSHCN in Texas can be fragmented and often difficult to access. In the National Survey of Children with Special Health Care Needs 2001, nearly one-fourth (23.2%) of respondents from Texas felt that community-based service systems were not organized so families can use them easily.[24] A 2003 report from the Texas Governor's Committee on People with Disabilities outlines a variety of barriers, including: long waiting lists for community-based services; complicated and duplicative application processes for services; shortages of personal care attendants and health care workers; shortages of affordable, accessible housing; and difficulty in obtaining adequate transportation services.[25]

As of May 2004, 5,116 adults and children were waiting for mental health services. This total includes 354 children who were receiving no mental health services currently, and 165 children currently receiving some mental health service. For Children's Services, the largest number of persons were waiting for services related to the following: 1) Medication; 2) In Home Family Support; 3) Skills training; and 4) Service Coordination.[26] Children with severe emotional disturbance and their families also face significant barriers. In a survey of local interagency groups, known as Community Resource Coordination Groups, 83% noted access to and availability of services as the

[22] National Survey of Children with Special Health Care Needs, Maternal and Child Health Bureau, 2001.
[23] "Tracking the Impact of Budget Cuts," Anne Dunkelberg (Center for Public Policy Priorities), Molly O'Malley (Kaiser Commission on Medicaid and the Uninsured), Kaiser Commission on Medicaid and the Uninsured: Children's Medicaid and SCHIP in Texas, July 2004.
[24] National Survey of Children with Special Health Care Needs, Maternal and Child Health Bureau, 2001.
[25] "Team Texas: Vision 2003," Governor's Committee on People with Disabilities, 2003. http://www.governor.state.tx.us/divisions/disabilities/publications
[26] TDMHMR Strategic Plan 2003-2007.

most frequent barriers limiting a community's ability to provide effective services for children with severe emotional disturbances and their families.[27]

Since 1998 the Texas Department of Mental Health and Mental Retardation (TDMHMR) (now part of the Department of Aging and Disability Services) has experienced a dramatic increase in the number of persons with mental retardation on the waiting list for home and community-based services waiver programs. As of May 2004, 9,112 children with mental retardation were on the waiting list for the Home and Community-Based Services Medicaid waiver program. Forty-eight percent (48%) of those waiting for Home and Community-Based Services receive no service currently. The majority of persons waiting for mental retardation services were waiting for: 1) community support services; 2) personal and family assistance services; 3) residential services; 4) respite; and 5) specialized services. [28]

For people with certain disabilities such as traumatic brain injury, service system barriers are even more widespread. Three-fourths of nearly 150 Texans responding to a survey regarding personal care assistance for people with traumatic brain injury indicated that they have unmet or under-met needs. Lack of appropriate services and inadequate access to the services available were cited as major barriers, along with lack of coordination among various programs within the service delivery system.[29]
Case management services provided by CSHCN regional staff and contractors assist families in identifying and accessing needed services and supports in their local communities. Case management services may be offered to CSHCN and their families whether or not they receive healthcare benefits through the CSHCN Services Program.

Changes in the Medicaid, CHIP, and CSHCN Services Programs resulted in continuous coverage being reduced from 12 months to 6 months. Through stakeholder feedback, families and providers voice considerable frustration with the need to reapply for benefits to Medicaid, CHIP, and the CSHCN Services Programs every six months.

The Children with Special Health Care Needs Program Rules (August 1, 2004), §38.16 detail procedures to address CSHCN program budget alignment. When the CSHCN program projects that the estimated amount of funds needed in the fiscal year by the program to serve CSHCN clients will exceed the program's appropriated funds and other available resources for the fiscal year, a waiting list for health care benefits is established for new applicants or re-applicants with lapsed eligibility who are determined eligible for program health care benefits. When the CSHCN program projects that the estimated amount of funds to be expended by the program in the fiscal year is less than the program's appropriated funds and other available resources, clients are removed from the waiting list in the following group order, based on CSHCN rules:

- Priority Group 1 - Clients who are less than 21 years old and who have an urgent need for health care benefits;

[27] "Children with Severe Emotional Disturbances – Report to the 79th Legislature," Texas Integrated Funding Initiative, Health and Human Services Commission, 2004 (Draft).
[28] TDMHMR Strategic Plan 2003-2007.
[29] "Final Report," Texas Traumatic Brain Injury Project, Submitted to MCH Bureau June 2004.

- Priority Group 2 - Clients who are 21 years of age or older and who have an urgent need for health care benefits;
- Priority Group 3 - Clients who are less than 21 years old who do not have an urgent need for health care benefits and who are clients who were placed on the waiting list when they were ongoing clients and who have had no lapse in eligibility while on the waiting list or who are new clients who are re-applicants for health care benefits and who have had a lapse in eligibility for no longer than the 12 months prior to the date/time that starts their latest uninterrupted sequence of eligibility;
- Priority Group 4 - Clients who are 21 years of age or older who do not have an urgent need for health care benefits and who are clients who were placed on the waiting list when they were ongoing clients and who have had no lapse in eligibility while on the waiting list or who are new clients who are re-applicants for health care benefits and who have had a lapse in eligibility for no longer than the 12 months prior to the date/time that starts their latest uninterrupted sequence of eligibility;
- Priority Group 5 - All other clients who are less than 21 years old who do not have an urgent need for health care benefits; and
- Priority Group 6 - All other clients who are 21 years of age or older who do not have an urgent need for health care benefits.

In accordance with CSHCN rules, 191 clients were removed from the CSHCN waiting list in FY03 and 1,344 clients were removed from the CSHCN waiting list in FY04 (347 removed effective 10/1/03 and 997 removed effective 5/1/04). An additional 395 clients were on the waiting list as of 8/31/04.[30] On March 1, 2005, 232 children were removed from the waiting list.

Depending on available funds when the CSHCN program projects that the estimated amount of funds to be expended by the program in the fiscal year is less than the program's appropriated funds and other available resources, outstanding bills may be paid for clients that have been removed from the waiting list. Outstanding bills are bills that meet the program's reimbursement criteria, have not been paid by the CSHCN program to date, and are for health care benefits that:

- have already been provided;
- are within the program's defined scope of health care benefits;
- were provided by an enrolled CSHCN provider;
- are limited in type, amount, scope, and/or duration and are not intended to be sustained over time only as long as projected cost savings or unobligated funds are available;
- have dates of service that are within the client's time period of eligibility for the program's health care benefits; and
- have dates of service that are within the time period that program cost savings and/or unobligated funds are available.

[30] DSHS CSHCN Services Program Data, FY2004.

Payment of outstanding bills was made available for clients removed from the waiting list on May 1, 2004, and for clients removed from the waiting list on March 1, 2005.

Depending on available funds when the CSHCN program projects that the estimated amount of funds to be expended by the program in the fiscal year is less than the program's appropriated funds and other available resources, limited health care benefits may be provided to clients on the CSHCN Services Program waiting list. Limited health care benefits are specified CSHCN Services Program health care benefits (which includes family support services) of limited type, amount, scope, and/or duration that may be provided to waiting list clients who remain on the waiting list. These benefits are not intended to be sustained over time and may be provided only as long as cost savings or unobligated funds are available, and provided that cost savings or unobligated funds are projected to be insufficient to remove clients from the waiting list and maintain continuous program health care benefits coverage for those clients, or when projected cost savings or unobligated funds may lapse if not expended in this manner. Limited health care benefits were offered to 541 clients on the CSHCN Services Program waiting list on March 1, 2005 for the period between March 1, 2005 and August 31, 2005 (depending on funding and other program factors). Payment for limited services was restricted to the following:

- Inpatient hospital and related services;
- Doctors' office visits; and
- Prescription drugs and syringes.

Transition to Adult Health Care

The data below provide some indicators of challenges faced by the teen population as a whole. Although it is certain that youth with special health care needs are impacted by these indicators, definitive data relative to those with special health care needs is not available.

Table 5 includes overall teen indicators reflecting significant challenges for Texas youth.[31]

Data Source: Kids Count 2004	State Ranking – 2001	Texas Rate - 2001	National Rate - 2001	Changes
Teen deaths by accident, homicide, suicide (ages 15-19)	27th	54 deaths per 100,000 teens ages 15-19	50 deaths per 100,000	Decreased in Texas by 19% between 1996 and 2001
Teen births (ages 15 – 17)	49th	39 per 100,000 females	25 per 100,000 females	Decreased in Texas by 19% between 1996 and 2001
Teens (ages 16 – 19) who are high school dropouts (not enrolled in school and are not high school graduates)	43rd	12%	9%	Decreased in Texas by 8% between 1996 and 2001
Teens (ages 16-19) who are not attending school and not working	32nd	10%	8%	
Young adults (ages 18-24) who live in poverty		22%	20%	

Despite improvements between 1996 and 2001, teen deaths by accident, homicide, or suicide exceed the national average. Births to teen mothers (ages 15-17) in Texas are significantly higher than the national average. The percentages of teens (ages 16-19) who are high school dropouts or who are not in school and not working exceed the national average, as does the percentage of young adults (ages 18-24) who live in poverty. [32]

A Texas Education Agency survey of parents of children in special education indicated that fewer than half of respondents understand the purpose of transition planning. The survey looked at post school activities and found that students who were in special education were significantly more likely to be currently unemployed (38%) as compared with students from the General Education cohort (23%). Approximately 30% of the Special Education cohort said that they were living away from home after high school as compared with 51.6% of the General Education cohort. Students who had been in special

[31] Kids Count Databook 2004.
[32] Ibid.

education were much less likely to be participating in community activities (32% of the Special Education cohort as compared with 89% of the General Education cohort).[33]

The Texas Effectiveness Study conducted by the Education Service Center Region XI utilized post-school surveys (2001 data) to provide a clear measure of post-school results of youth with disabilities as they transition from high school to adult life. The study generally supports conclusions from previous research. There was a high probability (87%) that persons with disabilities would be employed one year after graduation from high school if they held a job when they exited high school. Students with milder disabilities (e.g. learning disabilities versus mental retardation) had a higher probability of post high school employment. Academic achievement was significantly related to competitive employment. Students with high reading, writing, and math skills were two to three times more likely to be employed than those with lower skills. Graduation with a standard high school diploma was strongly associated with employment. Good social skills, job search skills, and work experience during high school also increased chances of employment.[34]

Several state agencies in Texas are involved in supporting the efforts of youth with special health care needs as they transition to adulthood. Over the past several years, agencies have collaborated to develop an integrated model for transition planning. The state law that required such collaboration was repealed by House Bill 2823, 78th Legislature, Regular Session, but the need for collaboration still exists. In its recent report to the Texas Legislature, the state's Children's Policy Council included the following key recommendations:

1. Develop a memorandum of understanding (MOU) among child and adult serving agencies to facilitate transition of children with disabilities and special health care needs to adult services;
2. Employ principles of self-determination in all health and human services enterprise policies and rules that impact children in order to promote a system of supports and services that focuses on the needs and desires of the individual with the support of the family;
3. Ensure that appropriate Health and Human Service agency field staff and contractors have sufficient expertise and training in transition and are available to assist youth with disabilities ages 18-25 in transitioning from children's services to adult services among the HHS agencies; and
4. Develop a mechanism at HHSC that allows children to transition to the most appropriate waiver for which they meet functional eligibility requirements, including Community Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), and Home and Community-based Services (HCS). [35]

The CSHCN Services Program maintains a section of its website to facilitate communication regarding transition issues for people with disabilities. Program staff also

[33] "Annual Performance Report for Part B of the Individuals with Disabilities Education Act (Part B) for Grant Year July 1, 2002 through June 30, 2003," Texas Education Agency, March 2004. (Cluster Area III – Parent Involvement) http://www.tea.state.tx.us/special.ed/apr/apr0203.html
[34] "Texas Effectiveness Study – Post School Survey" , Education Service Center Region XI, 2002-2003.
[35] "Making Children a Priority," Children's Policy Council Report to the Legislature, September 1, 2004.

collaborate with Dr. Albert Hergenroeder, Associate Professor at Baylor College of Medicine and Project Director for the Leadership Education in Adolescent Health (LEAH) Training Program. Articles on transition issues continue to be included in the CSHCN Services Program's Family Newsletter and Provider Bulletin.

Permanency Planning

Cost comparison data indicates that the annual cost per consumer receiving services through Home and Community-Based Services is significantly less than the annual cost per person in a State School[36]. Despite this, as of August 2004, 1,589 children with disabilities resided in long-term care facilities in Texas, including nursing facilities, state schools, intermediate care facilities for people with mental retardation, and group homes. Most programs that provide community-based services as an alternative to institutional care have lengthy waiting lists. As of July 31, 2004, more than 27,000 children were on waiting lists for Medicaid waiver program.[36] Families sometimes face few alternatives to institutional placement when they cannot access the supports and services they need to continue to care for their children in their own home and community.

DSHS regional social workers have received training and include permanency planning as part of case management services. The Children's Policy Council continued to develop priorities and recommendations to state leaders and the Health and Human Services Commission. Many of the recommendations covered in the report, "And How are the Children? Recommendations for Improving the Well-Being of Children with Disabilities in Texas"[37] were not implemented due to statewide budget constraints of the FY04/05 Biennium. One exception is the existing family-based alternatives project through EveryChild, Inc. The project provides a model for a statewide system of family-based alternatives for children with developmental disabilities living in institutions or at risk for institutional placement and targets approximately 300 children with developmental disabilities who live in facilities in 12 central Texas counties. Additionally, the Texas Community Integration Project (TCIP), a joint effort of the Texas Council for Developmental Disabilities with Advocacy, Inc., and the Texas Center for Disability Studies, assists people with disabilities of all ages who live in state schools, intermediate care facilities for persons with mental retardation, and nursing homes in moving into the community.

When there is a waiting list period for the CSHCN Services Program, family support services such as home or vehicle modifications and respite services are limited and may only be provided to ongoing clients who are at risk of institutionalization or for whom the provision of family support services is cost effective for the CSHCN Services Program.

[36] TDMHMR Rider 65 Cost Comparison Report, (FY 2000 Data), 2/2002.
[37] And How Are the Children? Recommendations for Improving the Well-Being of Children with Disabilities in Texas for House Bill 1478," Children's Policy Council, September 1, 2002.

II.B.5. Selection of Priority Needs

Women, Infants, Children and Adolescents Priority Needs

The state priority needs were determined through a process that combined stakeholder input (***qualitative data needs***) and subject matter review of health status and systems capacity data to determine ***quantitative data needs***. In section II.B.3., a summary of Attachment C, stakeholder input into state needs and state activity plans, provided an overview of the ***qualitative data needs***. MCH subject matter experts compared the ***qualitative data needs*** to the ***quantitative data needs*** to determine the most ***critical needs*** for the state, which are listed in the table below along with the recurrent themes that subject matter experts discovered in the comparison.

Critical Needs for Women and Infants

MCH Pyramid Level	Recurrent themes from stakeholder input and subject matter review of data	Critical needs
Direct Health Care Services	Stakeholders suggested expanding lactation consultant services to include care in pregnancy as well as postpartum. Overall percentage of breastfeeding in Texas is 40.5%. The percentage for White is 30.5%, for African Americans is 26% and for adolescents 15-19, 29.6%.	Increase breastfeeding for White, African American and adolescent mothers.
	Stakeholders felt that more providers needed to screen, identify, and treat postpartum depression. Research indicates a link between perinatal depression to low birth weight and other poor birth outcomes.	Increase awareness of postpartum depression in order to help women deal more effectively with this illness.
	Suicide rates are highest for White women 35-44 and linked to depression.	Reduce adult suicides
Population-based services	Stakeholders cited the need to address infant mortality, including deaths due to fetal exposure to tobacco, alcohol and illegal substances, SIDS, prematurity and low birth weight. Data indicate that the problem is most critical in the African American population.	Decrease infant mortality for African Americans.
	Stakeholders cited the need to address prematurity by increasing access to prenatal care, educating clients and providers about warning signs and risk conditions including fetal exposure to tobacco, alcohol and illegal substances, and ensuring that pregnant women are appropriately nourished. Data indicate that that problem is most critical in the African American population.	Decrease low birth weight births and/or premature births for African Americans.
	Stakeholders expressed considerable concern about overweight and obesity rates, as well as poor nutrition and physical activity habits and increasing rates of concomitant physical conditions such as cardiovascular disease and diabetes. The obesity rate in Texas is consistently higher than the U.S. rate. Data support this as a critical need for all populations.	Decrease adult obesity.

MCH Pyramid Level	Recurrent themes from stakeholder input and subject matter review of data	Critical needs
Population-based services	Stakeholders indicated a need to reduce family violence and abuse. Domestic violence (DV) increases during pregnancy. Homicide is the leading cause of death in the immediate pre- and post-delivery time period. The overall rate of DV for women in Texas is 13.23 and 33.43 for ages 20-29.	Reduce violence against women.
Infrastructure Building Services	Stakeholders cited increasing access to prenatal care as the top issue facing the women and infant population. Data indicate that the lowest rates of adequate prenatal care and early entry into prenatal care are for minority and teen populations. Stakeholders indicated that services for Spanish speaking clients needed to be expanded, with more options offered. Need for bilingual classes in the area of childbirth preparation, newborn care, postpartum care, and family planning methods. Research indicates that early and adequate prenatal care results in improved birth outcomes. Less than half of adolescents aged 10-14 receive early and adequate prenatal care.	Increase access to prenatal and other care, especially for teens and minorities.
The following stakeholder input on infrastructure building was integrated into the development of the final critical needs list above when feasible.		
	Stakeholders indicted that services could be expanded by increasing the number of providers; using mid-level providers; and reimbursing providers in a timely manner so more would take Medicaid.	Increase the number of health care providers.
	Stakeholders cited the needs for more comprehensive, integrated services delivery, information and data sharing, streamlined eligibility and improved referrals.	Ensure that social service programs work together to facilitate process for clients.
	Stakeholders indicated a need for more funding for virtually every need: increasing access; promoting nutrition, physical activity and breastfeeding; and screening, referral and treatment of issues including substance abuse and depression.	Increase funding.
	Stakeholders advocated more training for many issues including breastfeeding, domestic violence, substance abuse, overweight and obesity, prematurity and low birth weight prevention, available services such as WIC, etc.	Provide training.
	Stakeholders indicated that increased collaboration on multiple levels could address needs: public/private partnerships, partnering with school districts and local health departments, providing integrated screening and referral, etc.	Increase collaboration.

Critical Needs for Children and Adolescents

MCH Pyramid Level	Recurrent themes from stakeholder input and subject matter review of data	Critical needs
Direct Health Care Services	Stakeholders felt there was an overwhelming lack of access to dental care within Texas. Lack of access to dental care results in untreated dental caries and other oral health problems. Possible impacts may include chronic mouth pain, disrupted eating patterns and loss of school and work time for families. Dental caries is 5-7 times more common than reported respiratory disease among 5-17 year olds.	Increase access to dental care
	Reduce repeat teen pregnancies; Reduce teen rates of STDs/STIs; Reduce teen rates of chlamydia; Increase family planning services/education; increase responsible sexual behavior; increase sex education; increase male involvement in the prevention of teen pregnancy; increase abstinence education; increase high school completion rates; increase resiliency and developmental assets among adolescents.	Reduce rate of teen pregnancies and births
Enabling Services		
Population-based services	Because obesity is linked to decreased physical activity, diabetes, cardiovascular disease, joint pain and mobility problems, stakeholders imperatively stressed the need to focus efforts on education and outreach activities to curb the obesity epidemic. The obesity rate in Texas is consistently higher than the US rate. Among those with the highest rates in Texas are Hispanic children age 1-4.	Decrease incidence of obesity
	Unintentional injuries can result in traumatic brain injury and lifelong debilitating consequences for the child, family and society. Because they are the leading cause of death for Texas children 1-4 years of age, stakeholders believe injury prevention outreach and education should be a priority.	Increase unintentional injury prevention and safety
	Child abuse and neglect impact the mental health and productivity of victims and families and can result in injury, unintended pregnancy or STDs and can be repeated in succeeding generations. The highest rates occur among African Americans. Education and outreach are needed to help curb this issue.	Decrease the incidence of child abuse and neglect
	Untreated mental disorders result in loss of school and work time, loss of productivity, possible suicide or victim crime and increased family stress. Prevalence of mental disorders in juvenile justice facilities ranges from 50-75%. Early and periodic mental health screening was urged repeatedly by stakeholders as a priority need among Texas youth.	Increase mental health screening and service access
	Stakeholders stress that a lack of vision and hearing screens may lead to developmental delays in children, impacting academic success and future productivity.	Increase vision and hearing screening

MCH Pyramid Level	Recurrent themes from stakeholder input and subject matter review of data	Critical needs
Population-based services, continued	Undetected, these issues lead to lost school and work time, unintended pregnancies and STDs, increased family stress and repeat cycles of abuse. Stakeholders' felt taking an integrated approach at detecting the issues is a best practice to prevent teen pregnancy.	Increase health screening for domestic violence, sexual abuse and substance abuse
	Substance use/abuse is directly linked to motor vehicle crashes, adversely impacts the ability to make sound decisions, and can lead to cardiovascular, liver, gastrointestinal and mental health problems. Out reach and education activities were recurrently suggested by stakeholders.	Substance abuse prevention
	Teen pregnancy has a higher incidence of pre-term birth and low birth weight than for older women. Repeat pregnancies usually result in loss of school and work time and increased stress for the mother and family. Thus activities including public awareness and education were suggested by stakeholders as a means to reduce repeat teen pregnancy.	Reduce repeat teen pregnancy
	Youth developmental asset programs can lead to increased sexual responsibility (a Healthy People 2010 leading indicator), impacting the rates of sexually transmitted infections, teen pregnancy and other adolescent issues. Multi-faceted programs that teach life skills attempt to increase self worth and ease the transition to productive adulthood.	Increase resiliency and developmental assets among adolescents
	Increase responsible sexual behavior; Increase sex education; Increase male involvement in the prevention of teen pregnancy; Increase abstinence education; Increase high school completion rates; Increase resiliency and developmental assets among adolescents.	Reduce rate of teen pregnancies and births
Infrastructure Building Services	Early and periodic screening results in fewer adverse health outcomes. In 2004, 52% of Texas counties were designated as Health Professional Shortage Areas. Less than 60% of children eligible for Texas Health Steps were screened in 2003.	Increase health care infrastructure
	Almost 1 million infants and children are in licensed childcare and many more are cared for in unlicensed facilities. Although not a recognized or integrated system, poor quality childcare can adversely affect the health and safety of the children and families.	Improve the quality of care delivered through daycare facilities

The list of ***critical needs*** was sent to stakeholders for final prioritization on April 29, 2005 (Attachment E). Stakeholder results of prioritized critical needs are the following:

Women and infants

- Improve prenatal care – adolescents
- Reduce domestic violence
- Decrease adult obesity
- Decrease fetal exposure to smoking, alcohol and drugs
- Increase breastfeeding with African American women and adolescents
- Increase awareness of postpartum depression
- Decrease low birth weights for African Americans
- Decrease infant mortality for African Americans
- Decrease prematurity for African Americans
- Reduce adult suicide

Children and adolescents

- Reduce obesity
- Increase healthcare infrastructure
- Increase access to dental care
- Reduce repeat teen pregnancy
- Increase mental health screening
- Reduce child abuse and neglect
- Increase developmental assets for adolescents
- Increase screens for domestic violence, sexual abuse and substance use
- Substance abuse prevention
- Improve daycare facilities
- Decrease unintentional injuries
- Increase vision and hearing screening

Additional details of the stakeholder prioritization of all critical needs are in Attachment F.

After input from MCH stakeholders on prioritization of the critical needs, MCH subject matter experts compared the highest-ranked needs to the NPMs to determine which ones were aligned with the NPMs and would therefore be addressed through NPM activity plans. After this final comparison, the following needs were identified as the final state MCH priorities:

Population: Women & Infants
Reduce domestic violence
Reduce adult obesity *
Reduce fetal/maternal exposure to smoking, alcohol and other drugs*

Population: Children & Adolescents
Reduce obesity
Increase healthcare infrastructure*
Increase access to dental services*

*These are new priorities for FY06.

Performance measures and activity plans for state priority needs for women, infants, children and adolescents that carry over from FY05, which are to reduce domestic violence (for women/infants) and reduce obesity (for children/adolescents), are described in detail in the *State Narrative, Section IV., Priorities, Performance and Program Activities, State Performance Measures, Plan for the Coming Year.*

New state needs and performance measures
Performance measures and activity plans for the **new** state priority needs for women, infants, children and adolescents are as follows:

New priority need: Decrease adult obesity.
New State Performance Measure: The rate of obesity among women ages 18 and over

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.
Output Measure: Number of women enrolled in "Fit Families" program; average number of women attending each "Fit Families" class; number and topic of classes provided; number of pre-test surveys completed; number of post-test surveys completed, number of post-test surveys showing increased knowledge and positive behavioral change after participating in the "Fit Families" program.
Monitoring: Document class attendance; review pre- and posttest surveys.

Activity 2: Assess the effectiveness of the "WIC Wellness Works" (WWW) program on improving fruit and vegetable consumption, physical activity, role behavior and work climate in the 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, role behavior and work climate at end of one year's enrollment in "WIC Wellness Works."
Monitoring: Review of quantitative and qualitative analysis of changes in fruit and vegetable consumption, physical activity, role behavior and work climate.

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.
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

New priority need: Improve and expand healthcare infrastructure.
New State Performance Measure: The percent of day care facilities, which apply health promotion and risk reduction strategies.

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.
Output Measure: Number of licensed childcare facilities cited by Department of Family Protective Services (DFPS) Childcare Licensing for health and safety infractions; number and type of consultations and training completed by childcare health and medical consultants; number of childcare centers visited; number of new childcare health consultants trained by the National Training Institute (NTI).
Monitoring: Update the Service Encounter Database, which includes activity-reporting cards; generate data reports on the type of consultant providing the training/services, the type of contact, the topic, type and purpose of service(s) provided, the number of consultations/training provided by each consultant, number and type of participants, and location of training; track DFPS' reports every six months on the number and type of health and safety infractions made by child care center and geographic area; track the number of training conducted by NTI trainers; number of consultants trained.

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 NTI trainers or child care health consultants, thus increasing the network of child care health consultants. The plan is to train workforce staff in 5-6 local workforce areas per year.
Output Measure: Number of child care health consultants employed by TWC local workforce development areas; number of licensed childcare facilities cited by DFPS Childcare Licensing for health and safety infractions; increase the number of child care health consultants employed by TWC local workforce development areas.
Monitoring: Update the Service Encounter Database, which includes activity-reporting cards; generate data reports on the type of consultant providing the training/services, the type of contact, the topic, type and purpose of service(s) provided, the number of consultations/training provided by each consultant, number and type of participants, and location of training; track DFPS reports every six months on the number and type of health and safety infractions made by child care center and geographic area; track the number of training conducted by NTI trainers; number of consultants trained; review reports every six months on the number and type of health and safety infractions made by child care centers by geographic area.

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.
Output Measure: Number of licensed childcare facilities with infractions; number of consultations and training on child health and safety provided to community leaders and parents.
Monitoring: Update the Service Encounter Database, which includes activity-reporting cards; generate data reports on the type of consultant providing the training/services, the type of contact, the topic, type and purpose of service(s) provided, the number of consultations/training provided by each consultant, number and type of participants, and location of training; track DFPS' reports every six months on the number and type of health and safety infractions made by child care center and geographic area; track the number of training conducted by NTI trainers; number of consultants trained.

Activity 4: Childcare health consultants address problem areas as identified in the DFPS childcare licensing infraction reporting.
Output Measure: Number and type of consultations and training provided by childcare health and medical consultants; number of childcare facilities receiving consultation, number of licensed childcare facilities with health and safety infractions reported by DFPS to childcare health consultants.
Monitoring: Update the Service Encounter Database, which includes activity-reporting cards; generate data reports on the type of consultant providing the training/services, the type of contact, the topic, type and purpose of service(s) provided, the number of consultations/training provided by each consultant, number and type of participants, and location of training; track DFPS' reports every six months on the number and type of health and safety infractions made by child care center and geographic area; track the number of training conducted by NTI trainers; number of consultants trained.

New priority need: Decrease the number of childbearing women who smoke.
New State Performance Measure: The percent of women of childbearing age who smoke.

Activity 1: Promote smoking cessation to women ages 13-44, including pregnant women, through a Quitline/Great Start Faxed Referral Model.
Output Measure: Number of providers participating in the program; Number and type of smoking cessation materials; 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.

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.
Output Measure: Number of health care providers participating in the program; number of billboards; 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 distributed by gender, age, race, and ethnicity; summary report on smoking cessation among pregnant women in four-county area.
Monitoring: Review Quitline/Great Start data and media reports quarterly and follow-up the development of the summary report on smoking cessation among pregnant women in four-county area.

Activity 3: Conduct a survey addressing tobacco habits and history among women of childbearing age.
Output Measure: Survey tool completed; number of participants completing survey; summary results from the survey and related recommendations.
Monitoring: Follow-up progress on survey tool development and implementation.

Activity 4: Using Geographic Information Systems (GIS) and related data sets (ie: PRAMS, Birth Certificate data, etc.), identifies and compares areas of the state with the highest incidence of very low birth weight births and fetal exposure to tobacco, and develops and distributes 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.

Activity 5: Develop 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.

New priority need: Increase access to dental care.
New State Performance Measure: The percent of children provided preventive dental services.

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.
Output Measure(s): Number of children served by regional dental teams.
Monitoring: Review of Medicaid oral health data reports and screening survey reports.

Activity 2: Establish a state oral health coalition/collaboration and support for oral health prevention through water fluoridation and dental sealant.
Output Measure(s): State oral health coalition formed; number and description of goals and objectives addressed and/or achieved by the coalition.
Monitoring: Review of and track progress through semi-annual activity reports.

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.

The set of state activities described in this section plus the activities for the two priorities carried over from FY05 and the national activity plans comprise the Title V annual plan for FY06.

Children with Special Health Care Needs Priority Needs

The Texas Title V CSHCN priority needs were determined based on recurrent themes of need developed from all sources of information obtained during the Title V Five-Year CSHCN Needs Assessment process. These identified recurrent themes and priority needs relate primarily to Direct Health Care Services, Enabling Services, and Infrastructure Building Services. The 500 plus suggestions from stakeholders identified recurrent themes and priority needs that align with the Title V CSHCN national performance measures and with the one state-added performance measure, or subcomponents thereof.

Critical Needs for Children with Special Health Care Needs

MCH Pyramid Level	Recurrent Themes of Need	Priority Needs and Related Title V CSHCN National (NPM) or State-Added (SPM) Performance Measure
Direct Health Care Services	Increased capacity to provide health services for CSHCN (elimination of waiting list for the CSHCN Services Program health care benefits)	Increased access to and provision and coordination of adequate health services and public and/or private health insurance for CSHCN and their families - NPM 4
Enabling Services	Additional public awareness regarding programs and benefits for CSHCN	Increased awareness and improved access, coordination, organization, capacity, and cultural competency of community-based service systems so families can use them easily - NPM 5
	Increased availability of family support services for CSHCN and their families	Increased access to and provision and coordination of family support services, permanency planning, and other community care resources so that all children live with families in communities (no children reside in congregate care)- SPM 1
	Decrease in the number of CSHCN	Increased access to and provision

	living in nursing homes, state schools, group homes, or other institutions *	and coordination of family support services, permanency planning, and other community care resources so that all children live with families in communities (no children reside in congregate care)- SPM 1
	Access to adequate public or private health insurance with low or reasonable cost health insurance premiums *	Increased access to and provision and coordination of adequate health services and public and/or private health insurance for CSHCN and their families - NPM 4
	Increased meaningful family involvement in decision-making in programs serving CSHCN. *	Increased family partnership in decision-making and ongoing assessment of family satisfaction with services and recommendations for improvement- NPM 2
	Improved transportation systems*	Increased awareness and improved access, coordination, organization, capacity, and cultural competency of community-based service systems so families can use them easily- NPM 5
Infrastructure Building Services	Additional providers (doctors and other health care providers) for programs serving CSHCN	Increased awareness and improved access, coordination, organization, capacity, and cultural competency of community-based service systems so families can use them easily - NPM 5; and Increased access to and provision and coordination of adequate health services and public and/or private health insurance for CSHCN and their families- NPM 4
	Simplification of application and enrollment processes for the state's medical assistance programs	Increased awareness and improved access, coordination, organization, capacity, and cultural competency of community-based service systems so families can use them easily- NPM 5; and Increased access to and provision and coordination of adequate

		health services and public and/or private health insurance for CSHCN and their families- NPM 4
	Improved systems for helping youth with special health care needs transition to adult health services	Increased access to and provision and coordination of transition planning, preparation, and services necessary for youth to make successful transitions to adult health care and all aspects of adult life- NPM 6
	Understanding of the concept of a medical home and its value to CSHCN and their families by agencies, providers, policy makers and families	Increased knowledge and awareness of the importance and value of coordinated, ongoing, comprehensive care within a medical home and increased access to and provision and coordination of medical home services for CSHCN and their families- NPM 3
	Increased cultural competence in information and service delivery in programs serving CSHCN	Increased awareness and improved access, coordination, organization, capacity, and cultural competency of community-based service systems so families can use them easily- NPM 5

*Also reflects Infrastructure Building Services

As a result of the needs assessment, the Title V CSHCN efforts in Texas will focus on the five Title V CSHCN performance measures (NPM2-6) and one state-added performance measure (SPM 1).

While CSHCN SP considers all six of the national and state performance measures for which it is responsible to be priorities, 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:

1) Increase partnerships with families of CSHCN in decision-making at all levels and family satisfaction with the services they receive (NPM2, enabling and infrastructure-building)
2) Increase the number of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home (NPM3, enabling and infrastructure-building)
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 (NPM5, enabling and infrastructure-building)

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 (NPM6, enabling and infrastructure-building)

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 details of the Annual Plan to achieve the national and the one state-added performance measure are delineated in the body of the FY06 Title V application, *State Narrative, Section IV., Priorities, Performance and Program Activities, State Performance Measures, Plan for the Coming Year.*

II. C. Needs Assessment Summary

Women, Infants, Children and Adolescents

The five-year needs assessment process to determine state priority needs for MCH populations was based on multiple stages and a comparison of ***qualitative data needs*** derived from stakeholder input with ***quantitative data needs*** derived from MCH subject matter expert review of health status indicators, outcomes, performance measures, and system capacity indicators. ***Qualitative data needs*** were determined through primary data collection of qualitative data from a broad group of MCH stakeholders across the state. The ***qualitative data needs*** were compared to ***quantitative data needs***, resulting in a determination of ***critical needs*** for each MCH population group. The MCH subject matter experts considered the ability to control or influence systems capacity in the determination of ***critical needs***. Then, the ***critical needs*** list was sent to stakeholders to prioritize and select the top three ***priority needs*** for each population group. For the last phase of the five-year needs assessment process, MCH subject matter experts compared the ranked ***critical needs*** (Attachment F) from stakeholder input to national performance measures. The ***critical needs*** that align with national performance measures will be addressed through national activity plans. For example:

Related to NPM 8 – rate of teen births

- Reduce repeat teen pregnancy

Related to NPM 11 – breastfeeding

- Increase breastfeeding for African Americans and adolescents

Related to NPM 15 – very low birth weights

- Decrease low birth weights in African Americans

Related to NPM 17 – very low birth weight infants delivered at facilities for high-risk births

- Decrease prematurity for African Americans
- Decrease infant mortality for African Americans

Related to NPM 16 – suicide deaths among 15-19 year olds

- Increase mental health screening

Related to NPM 18 – early prenatal care

- Improve prenatal care for adolescents
- Decrease infant mortality for African Americans
- Decrease low birth weights in African Americans

The remaining priorities listed immediately below will be addressed through state activity plans.

Population: Women & Infants
Reduce domestic violence
Reduce adult obesity *
Reduce fetal/maternal exposure to smoking, alcohol and other drugs*

Population: Children & Adolescents
Reduce obesity
Increase healthcare infrastructure*
Increase access to dental services*

*These are new priorities for FY06.

As in FY05, reduction of domestic violence will be a priority need for women in FY06, and reduction of obesity is a carryover priority need for children in FY06.

Input from collaborative partnerships and stakeholder input was a key component in the selection of the state's priority needs and development of activity plans. Participants in these processes represent a broad base of input related to MCH issues, and the Title V program is committed to continuing to build and nurture these relationships.

Several ongoing mechanisms that currently exist to solicit stakeholder input will continue in an effort to inform the Texas Title V MCH Office and potentially lead to improved MCH services. One mechanism is the placement of the Title V grant application on the DSHS website, where the public can review it and make comments. The information will be integrated into planning for MCH services wherever feasible. Another activity is the ongoing participation of Title V MCH subject matter experts (i.e., Adolescent Health, Early Childhood, and Perinatal Coordinators) in national, state and local collaborations and partnerships focusing on issues related to MCH populations, including CSHCN. Some examples of these partnerships are the Texas Medical Association, the March of Dimes, the Association of Maternal and Child Health Programs, the Texas Education Agency, the Texas Health and Human Services Office of Early Childhood, and the National Network of State Adolescent Health Coordinators. This exchange of information is integrated into discussions of MCH population health status and promotion of best practices throughout the year for MCH needs assessment

and related planning processes, such as strategic planning within DSHS. A third mechanism for ongoing stakeholder input is through periodic meetings held with contractors and DSHS Regional staff to discuss program updates, policies, procedures, and successes and lessons learned. Valuable information is collected through this venue to improve the delivery of MCH services.

In an effort to continue to improve the process for stakeholder input, the Title V MCH Office plans to strengthen a local-level process to inform the state-level assessment process. One way to achieve this goal is to utilize the promotora system, a system of trained peers initially used in the Texas-Mexico border colonias that has been successful in Texas for many years. Promotoras provide cultural mediation between communities and the health and human services systems, informal counseling and support, culturally and linguistically appropriate health education, and referral and follow-up services. There are currently 526 trained promotoras across all Health Service Regions in Texas. Additionally, the Title V MCH Office plans to work with Title V-funded contractors to seek client input for improvements through surveys or other tools. This collection of local assessment data could assist in tailoring resources based on local needs.

CSHCN

The multi-tiered Title V CSHCN 5-year needs assessment conducted by the Texas CSHCN Services Program included review and analysis of primary and secondary health status data and stakeholder input from national and state sources. The Texas priority needs identified for CSHCN are consistent with, and help to address, critical issues and key recommendations identified by stakeholders, statewide advisory groups/councils, collaborative initiatives in which DSHS has a partnership role, MCH and other programs within DSHS, and other governmental agencies including education and social services.

The 500 plus suggestions from stakeholders identified recurrent themes and critical needs that align with the Title V CSHCN national performance measures (NPM2-6) and with the one state-added performance measure (SPM 1), or subcomponents thereof.

While CSHCN SP considers all six of the national and state performance measures for which it is responsible to be priorities, 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)
2) Increase the number of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home (NPM 3)
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)
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)

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.

Needs assessment is an ongoing process for the CSHCN Services Program (CSHCN SP). While CSHCN SP undertakes a major update of the needs assessment every five years, the needs of CSHCN in Texas are monitored on an ongoing basis in several ways. CSHCN SP central office staff and regional case management staff and service contractors regularly participate in state, regional and local multi-agency meetings to understand the needs of special populations and develop responses to address these needs. Key input and consumer involvement from these meetings are reported to the CSHCN SP Title V staff through stakeholder meeting record forms (SMR). CSHCN SP service contractors use the SMRs to report needs and recommendations generated by consumer advisory groups to the CSHCN SP Title V staff. CSHCN SP Title V staff use the SMRs to report on needs, recommendations, and opportunities generated by interagency policy and stakeholder work groups. CSHCN SP Title V staff who attend these meetings inform participants of the Title V performance measures and state progress so that these groups include this information in their strategic planning process, ongoing activities, reports, and recommendations.

Some of the stakeholders who responded and provided input to the 5-year needs assessment indicated their interest in collaborating with DSHS to achieve the Title V CSHCN performance measures. CSHCN SP Title V staff will outreach and involve these stakeholders in program activities and ongoing input/feedback opportunities.
The CSHCN SP Title V staff will explore gathering input on key CSHCN issues via the Texas Parent to Parent listserv (and other available listservs that are identified) as a means for statewide communication with families of CSHCN. The development of this listserv has been supported by a Champions for Progress Incentive Award.

Many formal data sources contribute to the CSHCN SP on-going needs assessment. Among the most used is the CSHCN National Survey dataset and the much anticipated second survey dataset. Data from Texas Medicaid and CHIP programs, Texas Education Agency, and others are utilized from time to time, as needed, to inform the needs assessment.

The CSHCN SP service contractors, in collaboration with the CSHCN SP Title V staff, are developing a set of core questions that will be used to survey families on the quality of services provided by the contractors and the CSHCN Services Program and on unmet needs for CSHCN. National Survey questions will be considered for inclusion. These core questions will be included in the contractors' family quality assurance survey instruments. Data from these surveys will be reported to CSHCN SP Title V staff. The service contractors are also reporting to CSHCN SP Title V staff regarding their efforts to support progress toward the Title V CSHCN performances measures, noting successes and barriers.

The CSHCN SP is exploring inserting a self-mailing questionnaire in the CSHCN SP health care benefits application or re-application to obtain family feedback on the quality of the CSHCN SP and the unmet needs of their CSHCN.

II. D. Health Status Indicators

Refer to Forms 20 and 21 on the Title V online system for the health status indicator data.

II. E. Outcome Measures

In FY04, Texas met two of the six national outcomes measures, which were the postneonatal mortality rate per 1,000 live births and the child death rate per 100,000 children aged 1-14. The remaining four outcome measures were not met, although there was improvement in three, which were the infant mortality rate per 1,000 live births, the neonatal mortality rate per 1,000 births, and the perinatal mortality rate per 1,000 live births plus fetal deaths. There was no change in the ratio of the black infant mortality rate to the white infant mortality rate and a slight worsening in the ratio of the black perinatal mortality rate to the white perinatal mortality rate. The table below compares the annual performance objectives and the annual indicators for Texas in 2004.

Outcome Measure	Annual Performance Objective	Annual Indicator 2004
#01 - Infant mortality rate per 1,000 live births	5.5	5.8
#02 - Ratio of the black infant mortality rate to the white infant mortality rate	1.7	2.4
#03 - Neonatal mortality rate per 1,000 births	3.5	3.7
#04 - Postneonatal mortality rate per 1,000 live births	2.4	2.1
#05 - Perinatal mortality rate per 1,000 live births plus fetal deaths	8.9	9.2
#06 - Child death rate per 100,000 children aged 1-14	23.1	22.8
#07 - Ratio of the black perinatal mortality rate to the white perinatal mortality rate	1	2.1

A review of the outcome measures that were met indicates that Texas has shown consistent improvement in mortality outcomes once the infant moves out of the perinatal and neonatal state. Mortality decreased in children who are older than 28 days, or past infancy (>12 months). For the past five years, Texas has either met or exceeded the annual performance objective for postneonatal mortality rate. This may be attributed to a decrease in deaths due to Sudden Infant Death Syndrome, improvements in the care of premature and low birth weight infants and efforts to reduce preventable birth defects such as some neural tube defects. In 2002, Texas did not meet the annual performance indicator for the child death rate. In 2003, the annual indicator for Texas increased, but in 2004, there was a significant decrease in the child death rate for Texas, exceeding the

annual performance indicator. This improvement may be attributed to efforts such as newborn screening, which through state mandated requirements assures that newborns are screened for several genetic disorders that can result in severe or fatal consequences if not detected and treated; Texas Health Steps, which provides early and periodic screening resulting in fewer adverse health outcomes; and the Safe Riders program, a partnership of DSHS and the Texas Department of Transportation, that distributes child car safety seats and provides education car seat safety checks and education to parents and other community partners.

Improvements in infant mortality, neonatal mortality and perinatal mortality may also be attributed to the same factors that led to improvement in the outcome measure for postneonatality rate; however, Texas needs to focus on factors that reduce the mortality of the fetus and very young infants (under 28 days). Activities planned to address national performance measures for breastfeeding, very low birth weight and access to prenatal care are all expected to positively impact these outcome measures.

Very little change has occurred around outcome measures two and seven. Other than minimal improvement in 2001, there has been virtually no change in the ratio of the black infant mortality rate to the white infant mortality rate. Similarly, for the state outcome measure, there has been little change. Although it is not immediately clear why there has been no improvement for these outcomes, the Texas experience mirrors the national data. Prematurity, low birth weight, SIDS and consequently, perinatal and infant mortality, continue to be disparately high in the African American population compared to the White and Hispanic populations. Current research into this disparity focuses on the Life Course Perspective, which considers a woman's health and well being throughout her lifetime, with special emphasis on inflammation, infection and stress as critical factors. While increasing the number of women who access adequate and early prenatal care is often considered to be the primary approach to reducing this disparity, this will only work if the prenatal care is presented in an approachable format and is designed to meet the specific needs of the at-risk population.

Studies show that pregnant women suffer high rates of physical and/or emotional abuse with profound consequences, including miscarriage, with homicide the leading cause of mortality for women in the perinatal period. Consequently, these activities are directly linked to fetal and perinatal mortality and may be indirectly linked to the other outcome measures. The activities to address the percent of female clients suspected of being victims of relationship violence include increasing screening and referral for domestic violence, increasing the number of collaborations around domestic violence and developing a DSHS webpage to educate and inform health care providers.

Some data indicate a link between obesity during pregnancy and the incidence of neural tube defects, some of which can be fatal or severely compromise the child. Also, some data 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 is high among African American women, obesity can play a role in the infant

death disparity. The activity plan to address the rate of obesity among women aged 18 and over includes collaborating with WIC to assess the effectiveness of two pilot programs, "Fit Families" and "WIC Wellness Works," in bringing about behavioral changes and improving the health status of women and their families. The plan also calls for conducting skills building workshops and provide technical assistance in order to facilitate the development of community collaborations around the topics of nutrition and physical activity.

Research shows a link between fetal exposure to alcohol, tobacco and controlled substances and birth defects, mental retardation, prematurity and low birth and weight. All of these conditions can lead to increased perinatal, infant, neonatal, postneonatal and child mortality. The activity plan for the state performance measure on the rate of women of childbearing age who smoke involves understanding the smoking habits of this population, the development and distribution of appropriate smoking cessation materials and collaboration with WIC, the Tobacco Prevention and Control Program, and Healthy Start to implement best practice models to reduce the smoking rate in the target population.

Infants who are breastfed from hospital discharge experience less respiratory and gastrointestinal disease, leading to fewer life threatening illnesses. They are also less likely to die from Sudden Infant Death Syndrome (SIDS). Research has shown that premature infants thrive best on breast milk, and are often released from the hospital sooner than their formula-fed counterparts. Breastfed premature babies are less likely to develop necrotizing enterocolitis (NEC), an often fatal gastrointestinal condition that destroys the intestinal tissue and which affects approximately 10% of very low birth weight babies. Data indicate that African American women have the lowest rate of breastfeeding, and increased breastfeeding by this population could be a factor in reducing the African American infant mortality disparity as well as improving these outcome measures. Activities such as working with hospitals to help them become Texas Ten Step hospitals, and thereby promote breastfeeding from birth, designing materials to promote breastfeeding specifically to African American families, and using peer counselors for outreach to promote breastfeeding may improve these outcome measures.

Very low birth weight (VLBW) babies face many challenges to survival throughout their first weeks of life, their first year and into childhood, including neurological and respiratory problems, NEC, cerebral palsy and failure to thrive. VLBW is almost always linked to prematurity, and while current practices have led to a reduction in the incidence of prematurity, Texas must address the clear disparities that exist for African Americans. Ultimately, reducing prematurity and consequently VLBW, will most likely require broad societal changes that reduce poverty, assure a medical home for each person, and minimize stress factors resulting from societal issues such as poverty and racism. The activity plan for reducing the number of VLBW births in Texas focuses on understanding why these births occur, the populations that are at greater risk, and the contributing risk factors. Based on this information, the FY06 plan proposes collaboration with current partners, such as the Healthy Start projects, and new partners to implement best practice models, such as the use of a Promotora/Community Heath Worker program. The plan

proposes continuation of the partnership with the March of Dimes on the Prematurity Campaign.

Women and teens with an unintended pregnancy may delay prenatal care, which may affect the health of the infant and the mother. Women of all ages may have unintended pregnancies, but some groups, such as teens, are at a higher risk. Teen mothers are more likely than mothers over age 20 to give birth prematurely. In 2002, the 7,315 girls under age 15 who gave birth in Texas were more than twice as likely to deliver prematurely than women ages 30 to 34 (21% and 9%, respectively). Activities to reduce teen births for teens aged 15-17 include abstinence education, the provision of funds for statewide family planning services, the identification and funding of areas with the highest rates of teen pregnancy, and increased awareness of disparities for Hispanic and African American teens. These activities are intended to impact the outcome measures of infant mortality, perinatal mortality, neonatal mortality, the ratio of black infant mortality to white infant mortality, and the child death rate for ages 1-14.

Another factor that can improve outcome measures is if VLBW infants are born in specialized facilities that have the experience, expertise and equipment necessary to effectively care for them. Identifying women at higher risk for delivering VLBW babies and ensuring delivery in specialized facilities reduces the risk incurred by delays in transport or by the mode of transport. The activity plan for increasing the number of VLBW infants born at appropriate facilities is developing a process to facilitate the appropriate referral 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 through various means, including the use of Geographic Information Systems (GIS) maps, the development and dissemination of educational materials for providers, the solicitation of input from stakeholders, and tracking of referral patterns in selected areas. The focus of the plan is to educate providers on options for high-risk deliveries and developing a better understanding at the state level of the current referral patterns. Anecdotal information from previous years indicates that referrals are often based more on professional relationships rather than efficacy or proximity of facilities.

Improving access to prenatal care and ensuring that the care is high quality, culturally competent and meaningful may also play a role in improving outcome measures. The activity plan for increasing the number of infants born to pregnant women receiving prenatal care beginning in the first trimester proposes to enhance the work of the Texas Comprehensive Women's Health Initiative to develop and implement a comprehensive, integrated women's health system that will maximize the resources for women seeking prenatal care. Numerous barriers exist in Texas to accessing prenatal care in a timely manner, including lack of easy access to care, lack of providers, transportation issues and cultural mores. Minimization or reduction of barrier to the access of prenatal care is the intent of these activities.

FY06 Texas Title V
Five-Year Needs Assessment

Attachments

Attachment A

FY06 Needs Assessment

Title V

5 Year Needs Assessment

July 2005

This document has been re-issued to support Title V Programs assessment of program performance and progress toward achieving stated 5 year goals and objectives [2006-2010] established in 2005.

I N F A N T S

Percent of Children 19-35 Months of Age with 4:3:1:3 Series* - *Infant*

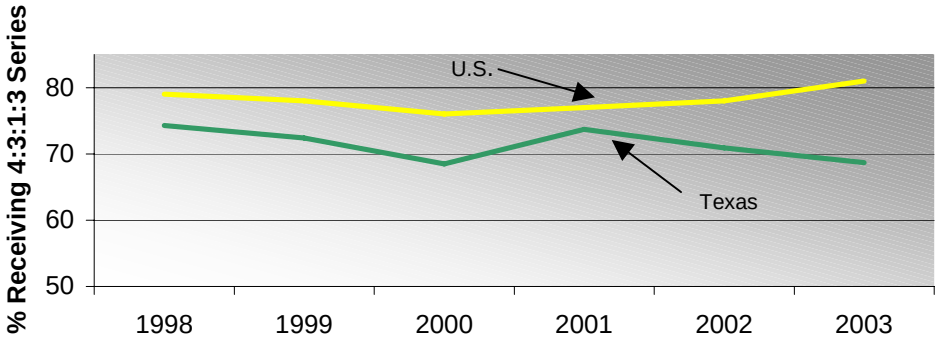
5-Year Trend

	1998	1999	2000	2001	2002	2003
Bexar County (San Antonio)	79.0	70.0	68.0	73.0	76.0	79.0
Dallas County (Dallas)	71.0	72.0	67.0	67.0	76.0	75.0
El Paso County (El Paso)	78.0	73.0	70.0	69.0	77.0	81.0
Houston	61.0	63.0	65.0	69.0	64.0	75.0
TEXAS	74.3	72.4	68.5	73.7	70.9	68.7

In 2003, the vaccination coverage among Texas children ages 19-35 months was 68.7%. The percentage has decreased every year since 1998, except in the year 2001.

Texas vs. US Comparisons

	Texas	U.S.
1998	74.3	79.0
1999	72.4	78.0
2000	68.5	76.0
2001	73.7	77.0
2002	70.9	78.0
2003	68.7	81.0



The percent of children 19-35 months of age with 4:3:1:3 series in Texas has decreased each year from 1994 through 1998, except in the year 2001. National numbers have been variable in the same time period. Texas percentages are consistently lower than national numbers.

Notes:

* The 4:3:1:3 combined series consists of 4 or more doses of diphtheria and tetanus toxoids and pertussis vaccine (DTP), diphtheria and tetanus toxoids (DT), or diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP), 3 or more doses of any
Urban areas were originally selected because they were at risk for undervaccination.
Final estimates from the National Immunization Survey include an adjustment for children with missing immunization provider data.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics and National Immunization Program, National Immunization Survey, Q1-Q4 2002.

Infant Mortality - *Infants*

PHR - 2002

PHR	All	White	Black	Hispanic
PHR 1	7.9	5.9	16.4	9.1
PHR 2	9.5	7.8	27.9	10.1
PHR 3	6.3	5.3	12.4	5.7
PHR 4	8.5	6.9	18.4	5.0
PHR 5	8.0	6.7	14.0	3.9
PHR 6	6.3	5.5	12.3	5.4
PHR 7	6.1	4.9	14.2	5.5
PHR 8	6.8	5.4	12.5	6.9
PHR 9	7.7	7.9	25.4	6.2
PHR 10	3.7	6.6	11.8	3.3
PHR 11	4.9	6.5	32.5	4.6
TEXAS	6.4	5.7	13.5	5.5

5-Year Trend

PHR	1998	2002
PHR 1	8.4	7.9
PHR 2	8.4	9.5
PHR 3	6.4	6.3
PHR 4	7.6	8.5
PHR 5	9.3	8.0
PHR 6	6.3	6.3
PHR 7	6.2	6.1
PHR 8	6.5	6.8
PHR 9	5.4	7.7
PHR 10	6.1	3.7
PHR 11	4.6	4.9
TEXAS	6.4	6.4

Race/Ethnicity - 1998 & 2002

Race/ Ethnicity	**1998**	**2002**
White	5.6	5.7
Black	11.6	13.5
Hispanic	5.9	5.5
Total	6.4	6.4

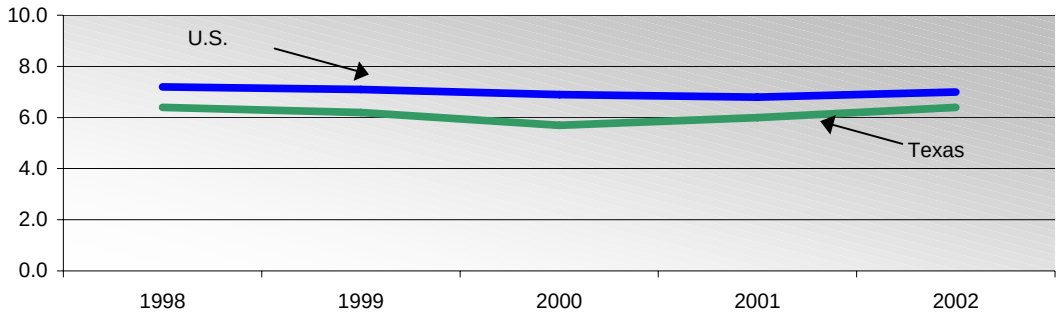
Texas vs. US Comparisons

	Texas	U.S.
1998	6.4	7.2
1999	6.2	7.1
2000	5.7	6.9
2001	6.0	6.8
2002	6.4	7.0

Disparity Between Black & White Infant Mortality

	IMR		Disparity
	White	Black	Black / White
1998	5.6	11.6	**2.1**
1999	5.1	12.5	**2.5**
2000	4.8	11.4	**2.4**
2001	5.2	12.0	**2.3**
2002	5.7	13.5	**2.4**

The Infant mortality rate (number of deaths to infants less than 1 year-of-age per 1,000 live births) in Texas continues to be lower than the national average.



There were 2,369 infant deaths to Texas residents in 2002 for an infant mortality rate (IMR) of 6.4 infant deaths per 1,000 live births. This is near the all time low for the State of Texas, which occurred in 2000 (2,064). However, the black infant mortality rate (13.5) continues to be markedly higher than the infant mortality rates for white infants (5.7) and for Hispanic infants (5.5). Congenital anomalies accounted for 22.1% of all infant deaths and Sudden Infant Death Syndrome (SIDS) accounted for 8.8%. Disorders related to short gestation and low birth weight accounted for 12.7% of infant deaths and respiratory distress syndrome involved 8.9% of infant deaths. Sixty-one percent of infant deaths took place during the first 27 days-of-life (neonatal period).

Source:
DSHS, Vital Statistics Unit, Natality and Mortality Files 1999-2002.
NCHS, Linked Birth/Infant Death Data Set

Sudden Infant Death Syndrome (SIDS) - *Infants*

PHR: 1999 - 2003

PHR	1998	1999	2000	2001	2002
PHR 1	1.48	0.66	0.16	0.25	0.33
PHR 2	0.81	1.20	1.89	0.69	0.96
PHR 3	0.55	0.70	0.74	0.64	0.71
PHR 4	1.37	0.73	1.14	0.72	0.69
PHR 5	1.20	0.91	1.37	1.13	1.11
PHR 6	0.57	0.50	0.50	0.29	0.32
PHR 7	0.74	0.47	0.78	0.51	0.61
PHR 8	0.35	0.57	0.43	0.46	0.66
PHR 9	0.48	0.49	0.85	0.25	1.60
PHR 10	0.61	0.63	0.14	0.27	0.14
PHR 11	0.45	0.26	0.44	0.35	0.32
TEXAS	0.64	0.58	0.64	0.48	0.56

The rate of deaths due to Sudden Infant Death Syndrome (SIDS) for infants less than 1 year-of-age per 1,000 births decreased in Texas from 1998 to 2002. The national average also decreased during this time. In 1999 and 2001 Texas was below the national average and in 2000 and 2002 Texas was above.

Race/Ethnicity of Infant - 2002

Race/ Ethnicity	Number	Rate
White	91	0.66
Black	42	1.01
Hispanic	72	0.40
Other	3	0.21
Total	208	0.56

Texas vs. U.S. Comparisons

	Texas	U.S.
1998	0.64	0.72
1999	0.58	0.67
2000	0.64	0.62
2001	0.48	0.56
2002	0.56	0.51

Sex of Infant - 2002

Sex	Number	Rate
Male	116	0.61
Female	92	0.50
Total	208	0.56

In 2002, the rate of deaths due to Sudden Infant Death Syndrome (SIDS) for resident infants less than 1 year-of-age per 1,000 births was 0.56, a decresse from 0.64 in 1998. Rates were highest for black infants (1.01 per 1,000 births) and lowest for Hispanic infants (0.40 per 1,000 births). In addition, rates for male infants (0.61 per 1,000 births) were higher than for female infants (0.50 per 1,000 births).

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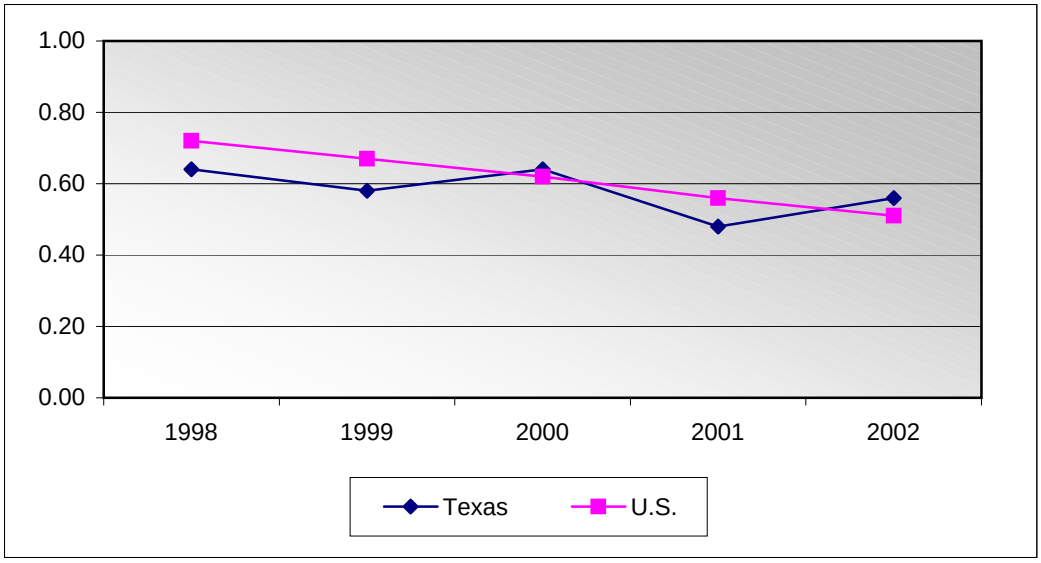


Source: DSHS, Vital Statistics Unit, Natality Files; NCHS, National Vital Statistics Reports, Report of Final Mortality Statistics, 1998-2002.

Neural Tube Defects - *Infants*

PHR: 1998 - 2002

	1998		2002	
	#	Rate	#	Rate
PHR 1	13	10.72	10	8.13
PHR 2	4	5.40	8	11.00
PHR 3	62	7.02	59	5.86
PHR 4	11	7.91	12	8.30
PHR 5	9	9.01	4	4.03
PHR 6	69	8.61	60	6.77
PHR 7	22	6.28	23	5.83
PHR 8	27	7.86	31	8.57
PHR 9	6	7.24	4	4.91
PHR 10	14	9.44	7	4.83
PHR 11	45	11.92	23	5.63
TEXAS	282	8.24	241	6.47

While the Texas rate of reported cases of neural tube defects per 10,000 births has decressed from from 1998 to 2002, the rate of neural tube defects is still higher than the national rate of 5.79.

Race/Ethnicity	Number	Rate
White	70	5.07
Black	33	7.95
Hispanic	133	7.45
Other/Unknown	5	3.51
Total	241	6.47

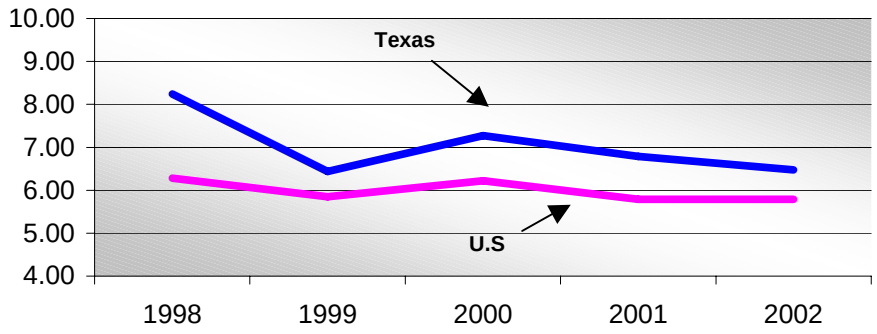
Texas vs. U.S. Comparisons

	Texas		U.S.	
	Number	Rate	Number	Rate
1998	282	8.24	2,417	6.28
1999	225	6.44	2,259	5.85
2000	264	7.27	2,471	6.22
2001	248	6.79	2,296	5.79
2002	241	6.47	2,295	5.79

Age of Mother - 2002

Age	Number	Rate
10-14	0	-
15-19	29	5.56
20-24	75	7.01
25-29	69	7.03
30-34	44	5.86
35-39	19	5.89
40+	5	7.30
Total	241	6.47

In 2002, an average of 6.47 per 10,000 Texas newborns were reported to have neural tube defects. Neural tube defects can include anencephalus, spina bifida/ meningocele, hydrocephalus, or microcephalus. In 2002, Black mothers were the most likely to have neural tube defect babies (7.95 per 10,000). This is a change from previous years when hispanic mothers had the higest rates. Mothers over the age of 40 had the higest rate of neural tube defects (7.30 per 10,000 births).



Source: DSHS, Vital Statistics Unit, Natality Files; NCHS, National Vital Statistics Reports, Report of Final Natality Statistics, 1998-2002.

W O M E N

Births 1998-2002

	1998	1999	2000	2001	2002
PHR 1	12,132	12,192	12,261	12,076	12,300
PHR 2	7,402	7,486	7,405	7,275	7,275
PHR 3	88,343	92,058	96,682	99,605	100,756
PHR 4	13,900	13,736	14,082	13,844	14,452
PHR 5	9,985	9,882	10,254	9,729	9,929
PHR 6	80,180	82,173	85,231	85,546	88,564
PHR 7	35,020	35,825	38,696	39,099	39,455
PHR 8	34,362	34,787	35,280	35,144	36,193
PHR 9	8,293	8,208	8,225	7,930	8,141
PHR 10	14,824	14,310	14,664	14,553	14,478
PHR 11	37,758	38,500	40,545	40,291	40,826
TEXAS	342,199	349,157	363,325	365,092	372,369

Birth Rates by Race/Ethnicity - 1998 & 2002[1]

Race/ Ethnicity	1998 Rate	2002 Rate
White	55.6	59.0
Black	70.5	67.1
Hispanic	116.3	101.7
Other	87.1	71.8
Total	75.8	75.8

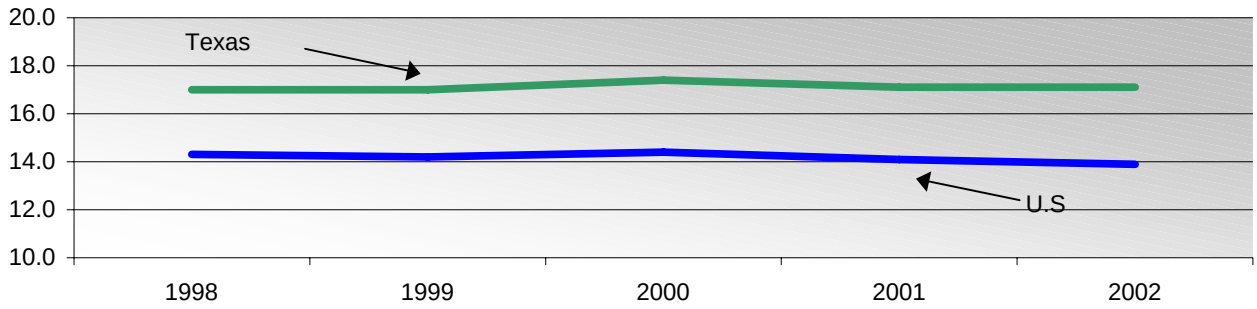
Crude Birth Rate Texas vs. US Comparisons[2]

	Texas	U.S.
1998	17.0	14.3
1999	17.0	14.2
2000	17.4	14.4
2001	17.1	14.1
2002	17.1	13.9

Age Specific Birth Rates - 1998 & 2002[3]

Mothers Age	1998 Rate	2002 Rate
<15	2.6	2.0
15-19	71.5	63.9
20-24	130.3	134.9
25-34	108.6	107.5
35-44	21.9	23.1
45+	0.3	0.4

In 2002, there were 372,369 births to Texas residents. The number of births has continued to increase each year. Over the last 5 years the crude birth rate has remained relatively steady at 17 births per 1,000 population. This rate has been higher than the US rate for the last 5 years. For Black and Hispanic populations, the birth rate has decreased from 1998 to 2002. The birth rate for the white population has increassed from 55.6 to 59.0 for the same period. Age specific rates show a decrease in rate of teen births and an increase in the number of births to women over 35.



Notes: All Rates are per 1,000

1. Birth rate by Race Ethnicity: Births to mothers 15-44 divided by the population of females 15 to 44 for the same race/ethnicity group.
2. Crude birth rate: Number of Births divided by Total Population
3. Age Specific Birth Rates: Total Births for the age group divided by the population of females in the age gorup. For <15 the denominator is 12-14 year olds and for 45+ the denominator is 45-49 year olds.

Source:
DSHS, Vital Statistics Unit, Natality Files 1999-2002.
NCHS, National Vital Statistics Reports, Vol 52, No. 10 December 17, 2003 and Vol 51, No. 12 August 4, 2003 (for 1998-2001 rates)
EPIGRAM 09/2004 update

Very Low Birth Weight Births - *Women*

PHR - 2002

	All	White*	Black	Hispanic
PHR 1	1.5%	1.0%	3.4%	1.8%
PHR 2	1.1%	0.9%	2.8%	1.1%
PHR 3	1.4%	1.1%	2.7%	1.2%
PHR 4	1.4%	1.1%	3.3%	1.0%
PHR 5	1.7%	1.4%	2.8%	1.1%
PHR 6	1.4%	1.2%	2.7%	1.1%
PHR 7	1.2%	1.0%	3.0%	1.1%
PHR 8	1.4%	1.3%	2.2%	1.4%
PHR 9	1.3%	1.2%	3.3%	1.2%
PHR 10	1.0%	0.9%	2.8%	1.0%
PHR 11	1.1%	1.2%	4.1%	1.1%
TEXAS	1.3%	1.1%	2.8%	1.2%

5-Year Trend

	1998	2002
PHR 1	1.5%	1.5%
PHR 2	1.2%	1.1%
PHR 3	1.3%	1.4%
PHR 4	1.4%	1.4%
PHR 5	1.5%	1.7%
PHR 6	1.5%	1.4%
PHR 7	1.3%	1.2%
PHR 8	1.4%	1.4%
PHR 9	1.2%	1.3%
PHR 10	1.0%	1.0%
PHR 11	0.9%	1.1%
TEXAS	1.3%	1.3%

Race/Ethnicity & Age - 2002

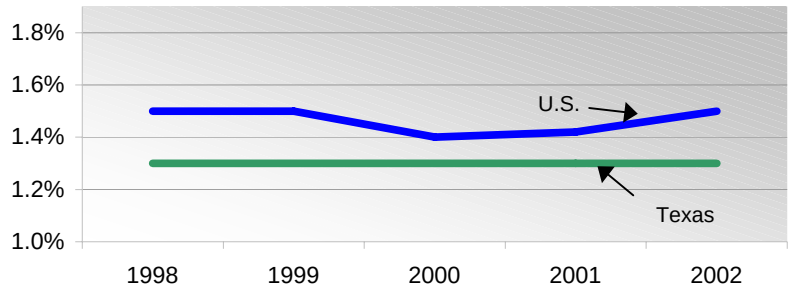
Race/	All Births		Singleton Births	
Ethnicity	#	%	#	%
White*	1,714	1.1%	1,162	0.8%
Black	1,160	2.8%	943	2.3%
Hispanic	2,102	1.2%	1,684	1.0%
Total	4,976	1.3%	3,789	1.0%

Age	#	%	#	%
10-14	32	3.2%	20	2.0%
15-19	816	1.6%	687	1.3%
20-24	1,303	1.2%	1,037	1.0%
25-29	1,157	1.2%	862	0.9%
30-34	971	1.3%	683	0.9%
35-39	548	1.7%	395	1.3%
40+	145	2.1%	101	1.6%
Unknown	4	12.1%	4	12.1%
Total	4,976	1.3%	3,789	1.0%

Texas vs. US Comparisons

	Texas	U.S.
1998	1.3%	1.5%
1999	1.3%	1.5%
2000	1.3%	1.4%
2001	1.3%	1.4%
2002	1.3%	1.5%

The percent of very low birth weight (VLBW) births in Texas has remained at 1.3% since 1996. Nationally, VLBW births have increased from 1.4% in 1996 to 1.5% in 2002. The percent of VLBW births in Texas is consistently somewhat lower than the national average.



In 2002, 1.3% of all live births to Texas residents were very low birth weight (VLBW) births (less than 1,500 grams [3 pounds, 4 ounces]). This represents a flat trend from 1996, when Texas VLBW births increased from 1.2% to 1.3%. The incidence of low birth weight infants is higher among the youngest and oldest mothers, in part because of multiple births associated with older mothers. In 2002, there were 10,127 sets of twins, 443 sets of triplets, 24 sets of quadruplets, 5 sets of quints, and one set of septuplets born in Texas.

Even controlling for multiple births, the risk of giving birth to a very low birth weight singleton infant was much higher for black mothers (2.3%) than for white mothers (0.8%) or Hispanic mothers (1.0%). The rate of singleton VLBW infants in Texas in 2002 was 1.0%, the same as reported in 1998.

* Includes Other and Unknown Race/Ethnicity

Source: DSHS, Vital Statistics Unit, Natality Files; NCHS, National Vital Statistics Reports, Report of Final Natality Statistics.

Low Birth Weight Births - *Women*

PHR - 2002

	All	White*	Black	Hispanic
PHR 1	8.9%	8.0%	14.7%	9.2%
PHR 2	7.8%	7.2%	14.5%	8.0%
PHR 3	7.6%	7.1%	12.6%	6.3%
PHR 4	7.9%	6.9%	14.2%	5.2%
PHR 5	8.2%	7.4%	11.9%	5.8%
PHR 6	7.8%	7.2%	12.7%	6.5%
PHR 7	7.2%	6.6%	12.4%	6.5%
PHR 8	7.9%	7.3%	12.2%	7.9%
PHR 9	8.7%	8.4%	16.5%	8.2%
PHR 10	8.0%	8.8%	14.2%	7.8%
PHR 11	7.3%	7.2%	11.4%	7.2%
TEXAS	7.7%	7.1%	12.7%	7.0%

5-Year Trend

	1998	2002
PHR 1	9.0%	8.9%
PHR 2	7.4%	7.8%
PHR 3	7.5%	7.6%
PHR 4	7.8%	7.9%
PHR 5	8.1%	8.2%
PHR 6	7.4%	7.8%
PHR 7	7.2%	7.2%
PHR 8	7.3%	7.9%
PHR 9	8.1%	8.7%
PHR 10	7.2%	8.0%
PHR 11	6.7%	7.3%
TEXAS	7.4%	7.7%

Race/Ethnicity & Age - 2002

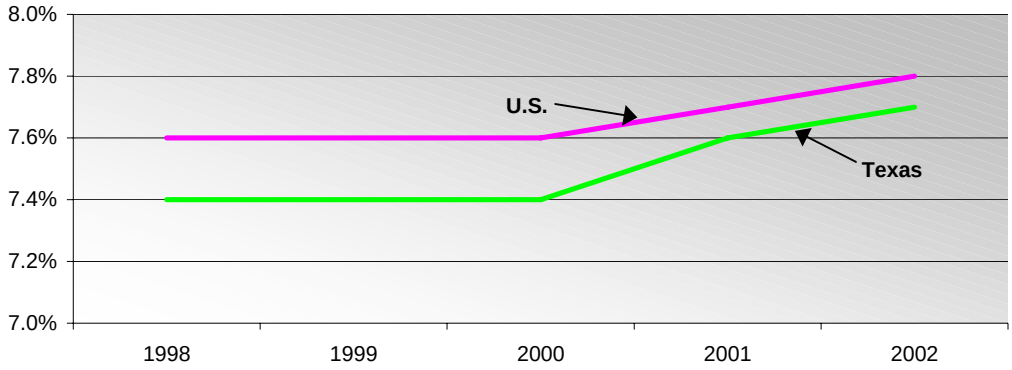
Race/	All Births		Singleton Births	
Ethnicity	#	%	#	%
White	10,860	7.1%	7,790	5.3%
Black	5,288	12.7%	4,368	10.9%
Hispanic	12,501	7.0%	10,097	5.8%
Total	28,649	7.7%	22,255	6.2%

Age	#	%	#	%
10-14	131	13.0%	107	10.9%
15-19	4,693	9.0%	4,136	8.1%
20-24	7,971	7.5%	6,529	6.2%
25-29	6,636	6.8%	5,064	5.3%
30-34	5,545	7.4%	3,861	5.3%
35-39	2,892	9.0%	2,011	6.6%
40+	776	11.3%	542	8.4%
Unknown	5	15.2%	5	15.2%
Total	28,649	7.7%	22,255	6.2%

Texas vs. US Comparisons

	Texas	U.S.
1998	7.4%	7.6%
1999	7.4%	7.6%
2000	7.4%	7.6%
2001	7.6%	7.7%
2002	7.7%	7.8%

The percent of low birth weight (LBW) births slightly increased in Texas and nationally from 1998 to 2002. However, the percent of LBW births in Texas was consistently lower than the national average for each year during this period.



In 2002, 7.7% of all live births to Texas residents were low birth weight (LBW) births (less than 2,500 grams or 5 pounds, 9 ounces). This represented an increase of 4.1% from 1998, when 7.4% of births were LBW. The percent of LBW singleton births increased about 3.3% from 1998 (6.0% LBW births) to 2002 (6.2% LBW births).
The risk of giving birth to a low birth weight infant remained much higher for black mothers (12.7%) than for white mothers (7.1%) or Hispanic mothers (7.0%). The incidence of low birth weight infants was higher among the youngest and oldest mothers. In 2002, 13.0% of births to mothers aged 14 and younger and 11.3% of births to mothers aged 40 and older were LBW.

* Includes Other and Unknown Race/Ethnicity

Source : DSHS, Vital Statistics Unit, Natality Files; CDC, NCHS, National Vital Statistics Reports, 1998-2002.

Maternal Mortality - *Women*

	Mortality #'s: 2000-2002			2002 Rate
	2000	2001	2002	per 100,000
PHR 1	2	1	3	24.4
PHR 2	0	0	1	13.7
PHR 3	6	13	8	7.9
PHR 4	1	3	2	13.8
PHR 5	1	2	1	10.1
PHR 6	8	11	12	13.5
PHR 7	6	3	1	2.5
PHR 8	0	4	1	2.8
PHR 9	1	1	0	-
PHR 10	0	0	1	6.9
PHR 11	5	2	4	9.8
TEXAS	30	40	34	9.1

	5-yr Rate Trend	
	1998	2002
PHR 1	8.2	24.4
PHR 2	-	13.7
PHR 3	6.8	7.9
PHR 4	-	13.8
PHR 5	-	10.1
PHR 6	3.7	13.5
PHR 7	-	2.5
PHR 8	11.6	2.8
PHR 9	-	-
PHR 10	6.7	6.9
PHR 11	-	9.8
TEXAS	4.4	9.1

Race/Ethnicity & Age - 2002

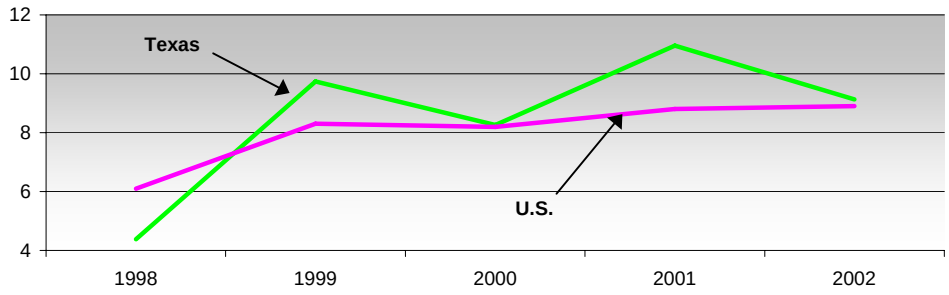
Race/ Ethnicity	#	Rate
White	9	6.5
Black	11	26.5
Hispanic	12	6.7
Other	2	14.0
Total	34	9.1

Age	#	Rate
10-14	0	-
15-19	3	5.8
20-24	5	4.7
25-29	6	6.1
30-34	12	16.0
35-39	5	15.5
40+	3	43.8
Total	34	9.1

Texas vs. US Comparisons

		Rate per 100,000	
	Texas #	Texas	U.S.
1998	15	4.4	6.1
1999	34	9.7	8.3
2000	30	8.3	8.2
2001	40	11.0	8.8
2002	34	9.1	8.9

In Texas, the maternal mortality rate fluctuated from 1998 through 2002. The lowest rate of 4.4 occurred in 1998 and the highest rate of 11.0 occurred in 2001. The rates based on small numbers of maternal deaths might be misleading. The national maternal mortality rate has shown an increasing trend from 1998 through 2002. The rate in Texas was higher than the national average for each year except 1998.



In 2002, 34 Texas residents died as a result of pregnancy or childbearing, for a maternal mortality rate of 9.1 per 100,000 live births. The maternal mortality rate for black women of 26.5 continued to be more than double the state rate. White and Hispanic women had maternal mortality rates of 6.5 and 6.7, respectively. The maternal mortality rate was much lower for younger women (ages 15-29) than for older women (ages 30 or more).

Note: - the rate is not computed if the number of deaths is equal to zero.
Source : DSHS, Vital Statistics Unit, Natality & Mortality Files; CDC, NCHS, National Vital Statistics Reports, 1998-2002.

Fetal and Neonatal Mortality Rates * - *Women*

PHR - 2002

	Fetal	Neonatal
PHR 1	6.3	4.8
PHR 2	7.1	5.6
PHR 3	6.3	4.0
PHR 4	5.3	5.1
PHR 5	4.0	4.3
PHR 6	5.1	3.9
PHR 7	6.0	3.8
PHR 8	5.5	4.1
PHR 9	6.8	4.4
PHR 10	3.9	1.9
PHR 11	5.7	3.2
TEXAS	5.7	3.9

5-Year Trend

	Fetal Mortality		Neonatal Mortality	
	1998	2002	1998	2002
PHR 1	6.2	6.3	5.3	4.8
PHR 2	6.1	7.1	5.1	5.6
PHR 3	5.4	6.3	4.2	4.0
PHR 4	6.5	5.3	4.2	5.1
PHR 5	6.2	4.0	5.3	4.3
PHR 6	5.8	5.1	3.7	3.9
PHR 7	6.3	6.0	3.6	3.8
PHR 8	5.4	5.5	4.5	4.1
PHR 9	6.8	6.8	3.6	4.4
PHR 10	6.4	3.9	3.8	1.9
PHR 11	5.3	5.7	2.9	3.2
TEXAS	5.8	5.7	4.0	3.9

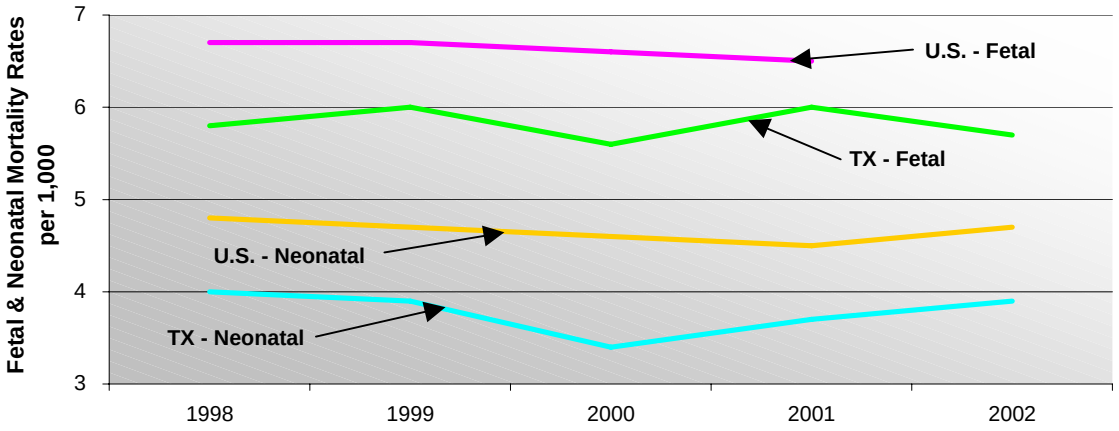
Neonatal Mortality
Race/Ethnicity - 2002

Race/ Ethnicity	Number	Rate
White	462	3.3
Black	347	8.4
Hispanic	617	3.5
Other	26	1.8
Total	1,452	3.9

Texas vs. US Comparisons

	Fetal		Neonatal	
	Texas	U.S.	Texas	U.S.
1998	5.8	6.7	4.0	4.8
1999	6.0	6.7	3.9	4.7
2000	5.6	6.6	3.4	4.6
2001	6.0	6.5	3.7	4.5
2002	5.7	NA	3.9	4.7

In Texas, the fetal death rate fluctuated between 5.6 and 6.0 from 1998 through 2002, and the neonatal death rate decreased from 1998 through 2000 and then increased in 2001. Nationally, both the fetal death rate and the neonatal death rate decreased from 1998 through 2001 and were consistently higher than the Texas average.



There were 2,108 fetal deaths to Texas residents in 2002 and the fetal death rate dropped to 5.7 fetal deaths per 1,000 live births in 2002 compared to 6.0 in 2001. Nationally, the fetal death rate dropped from 6.7 in 1998 to 6.5 in 2001 and was consistently higher than Texas fetal death rate for each year from 1998 through 2001. In 2002, the risk of neonatal deaths in Texas was much higher for black infants (8.4 per 1,000) than for white (3.3) or Hispanic (3.5) infants.

Note : * per 1,000 live births.
Source : DSHS, Vital Statistics Unit, Natality & Mortality Files; CDC, NCHS, National Vital Statistics Reports, 1998-2002.

PHR - 2002

	All	White*	Black	Hispanic
PHR 1	77.0%	84.5%	66.8%	69.5%
PHR 2	83.4%	87.0%	76.9%	75.3%
PHR 3	79.5%	85.7%	74.0%	73.0%
PHR 4	82.8%	87.0%	75.6%	74.9%
PHR 5	85.0%	87.6%	77.5%	85.9%
PHR 6	81.3%	88.9%	78.3%	75.5%
PHR 7	84.5%	90.9%	79.9%	76.1%
PHR 8	87.1%	92.7%	82.9%	84.6%
PHR 9	79.0%	85.2%	70.3%	75.3%
PHR 10	66.9%	82.1%	75.4%	65.1%
PHR 11	75.0%	86.0%	85.9%	73.8%
TEXAS	80.5%	87.8%	76.8%	75.1%

5-Year Trend

	1998	2002
PHR 1	76.7%	77.0%
PHR 2	80.5%	83.4%
PHR 3	81.3%	79.5%
PHR 4	79.3%	82.8%
PHR 5	82.4%	85.0%
PHR 6	81.9%	81.3%
PHR 7	81.5%	84.5%
PHR 8	84.7%	87.1%
PHR 9	73.3%	79.0%
PHR 10	65.7%	66.9%
PHR 11	68.9%	75.0%
TEXAS	79.3%	80.5%

Race/Ethnicity & Age - 2002

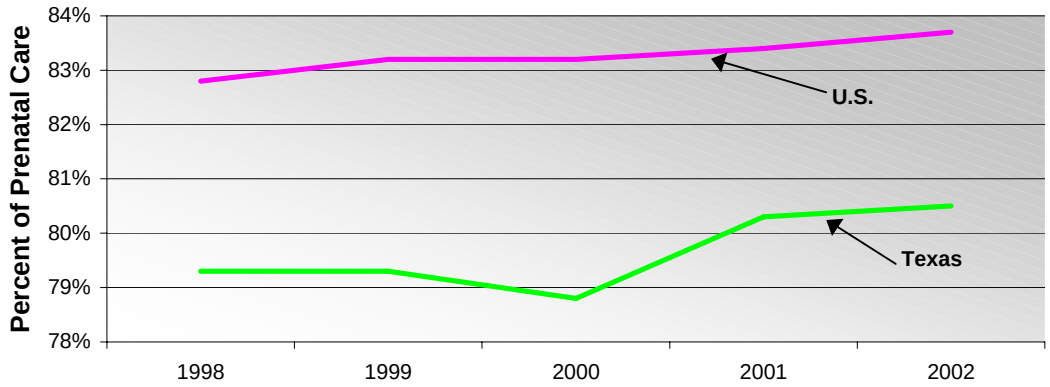
Race/ Ethnicity	#	%
White	132,382	87.8%
Black	31,215	76.8%
Hispanic	131,687	75.1%
Total	295,284	80.5%

Age	#	%
10-14	536	54.3%
15-19	35,228	68.7%
20-24	80,671	76.6%
25-29	81,389	84.1%
30-34	64,519	87.2%
35-39	27,356	86.2%
40+	5,572	83.0%
Unknown	13	59.1%
Total	295,284	80.5%

Texas vs. US Comparisons

	Texas	U.S.
1998	79.3%	82.8%
1999	79.3%	83.2%
2000	78.8%	83.2%
2001	80.3%	83.4%
2002	80.5%	83.7%

In Texas, the percent of births to women with onset of prenatal care within the first trimester was unchanged from 1998 to 1999 and increased from 2000 through 2002. Nationally, this percentage increased from 1998 through 2002. The percent in Texas was consistently lower than the national average for each year during 1998 -2002.



In 2002, 80.5% of all live births to Texas residents were to women who began prenatal care during the first trimester of pregnancy. This represented an increase of 1.5% from 1998, when 79.3% of all Texas resident births began prenatal care during the first trimester of pregnancy. In 2002, only 1.9% of Texas resident births were to women who reported receiving no prenatal care. White women were more likely than black or Hispanic women to begin care during the first trimester. Women ages 10-14 were the least likely to receive early prenatal care (54.3%) whereas women ages 30-34 were the most likely to receive early prenatal care (87.2%).

* Includes Other and Unknown Race/Ethnicity

Source : DSHS, Vital Statistics Unit, Natality Files; CDC, NCHS, National Vital Statistics Reports,1998-2002.

PHR - 2002

	All	White*	Black	Hispanic
PHR 1	68.5%	77.3%	53.5%	60.1%
PHR 2	73.9%	78.2%	67.4%	63.8%
PHR 3	70.7%	78.8%	64.9%	61.6%
PHR 4	75.4%	81.6%	66.1%	61.5%
PHR 5	79.9%	83.0%	72.5%	78.6%
PHR 6	71.6%	81.3%	68.7%	63.9%
PHR 7	77.6%	85.3%	73.0%	67.4%
PHR 8	83.1%	90.1%	78.4%	80.0%
PHR 9	72.3%	79.8%	67.1%	67.1%
PHR 10	54.1%	73.8%	70.2%	51.4%
PHR 11	66.9%	81.3%	72.9%	65.3%
TEXAS	72.3%	81.4%	68.1%	65.4%

5-Year Trend

	1998	2002
PHR 1	68.9%	68.5%
PHR 2	73.1%	73.9%
PHR 3	73.3%	70.7%
PHR 4	73.0%	75.4%
PHR 5	77.1%	79.9%
PHR 6	74.9%	71.6%
PHR 7	76.2%	77.6%
PHR 8	80.4%	83.1%
PHR 9	64.3%	72.3%
PHR 10	52.4%	54.1%
PHR 11	61.2%	66.9%
TEXAS	72.1%	72.3%

Race/Ethnicity & Age - 2002

Race/ Ethnicity	% Receiving Adequate PNC	% Receiving Inadequate PNC
White	81.4%	4.2%
Black	68.1%	8.9%
Hispanic	65.4%	10.4%
Total	72.3%	7.7%

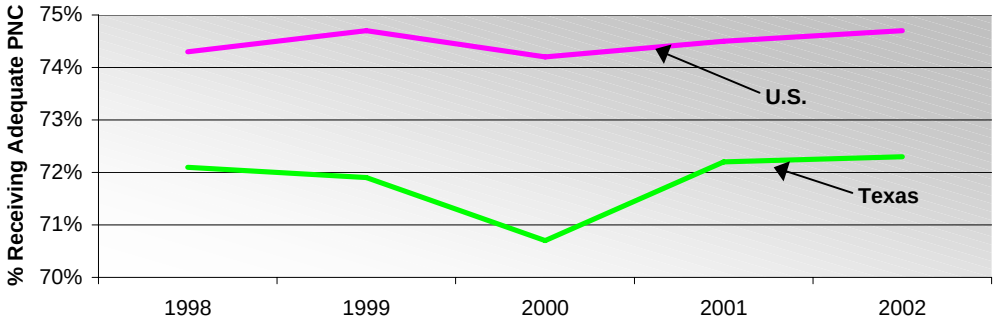
Age	% Receiving Adequate PNC	% Receiving Inadequate PNC
10-14	46.3%	16.1%
15-19	60.1%	11.4%
20-24	68.0%	8.9%
25-29	76.2%	6.5%
30-34	79.2%	5.6%
35-39	78.3%	5.8%
40+	74.8%	7.4%
Unknown	42.1%	26.3%
Total	72.3%	7.7%

Texas vs. US Comparisons

	Texas	U.S.*
1998	72.1%	74.3%
1999	71.9%	74.7%
2000	70.7%	74.2%
2001	72.2%	74.5%
2002	72.3%	74.7%

* U.S. rates based on The Adequacy of Prenatal Care Utilization Index (APNCU)

The Kessner Index is a measure of the adequacy of prenatal care. It incorporates three items recorded on the birth certificate - the length of gestation, when prenatal care began, and the number of prenatal visits.



In 2002, 72.3% of all live births to Texas residents were to women receiving adequate prenatal care, while only 7.7% received inadequate prenatal care, as measured by the Kessner Index. This was lower than the national rate of 74.7%. White women were more likely to receive adequate prenatal care (81.4%) than black women (68.1%) or Hispanic women (65.4%). Hispanic and black women were much more likely to receive inadequate prenatal care (10.4% and 8.9% respectively) than white women (4.2%). It also appeared that the youngest women (ages 10-14) giving birth were less likely to receive adequate care (46.3%), and that younger women (ages 10-24) were more likely to receive inadequate care (women ages 10-14 = 16.1%, ages 15-19 = 11.4%, and ages 20-24 = 8.9%) than older women (ages 25+).

* Includes Other and Unknown Race/Ethnicity

Note : Adequacy of prenatal care for Texas is based on Kessner Index
(see Page 291 of 2000 Texas Vital Statistics Annual Report for explanation of the Kessner Index).

Source : DSHS, Vital Statistics Unit, Natality Files; CDC, NCHS, National Vital Statistics Reports, 1998-2002.

Births by Type of Provider - *Women*

PHR - 2002

	Hospital	Licensed Birthing Center	Clinic/ Doctor's Center	Hispanic Residence	Other	All
PHR 1	12,232	2	0	62	4	12,300
PHR 2	7,243	2	0	25	5	7,275
PHR 3	100,015	277	0	433	31	100,756
PHR 4	14,325	37	0	86	4	14,452
PHR 5	9,896	3	0	29	1	9,929
PHR 6	88,135	128	0	263	38	88,564
PHR 7	39,027	110	1	292	25	39,455
PHR 8	36,055	45	0	89	4	36,193
PHR 9	8,120	0	0	15	6	8,141
PHR 10	14,219	239	0	11	9	14,478
PHR 11	40,249	463	5	102	7	40,826
TEXAS	369,516	1,306	6	1,407	134	372,369

Race/Ethnicity - 2002

	Hospital	Licensed Birthing Center	Clinic/ Doctor's Center	Hispanic Residence	Other	All
White	136,626	451	0	995	46	138,118
Black	41,380	21	0	93	26	41,520
Hispanic	177,317	809	6	287	55	178,474
Other	14,193	25	0	32	7	14,257
Total	369,516	1,306	6	1,407	134	372,369

Age - 2002

	Hospital	Licensed Birthing Center	Clinic/ Doctor's Center	Hispanic Residence	Other	All
13-17	19,617	47	1	32	7	19,704
18-19	33,268	79	3	39	12	33,401
20-24	106,331	336	2	246	43	106,958
25-34	171,633	693	0	789	50	173,165
35-44	38,277	149	0	294	17	38,737
45+	337	1	0	6	1	345
Total	369,463	1,305	6	1,406	130	372,310

Source : DSHS, Vital Statistics Unit, Natality Files, 2002.

Pregnancy Associated Hypertension Percentages - *Women*

PHR - 2002

	All	White	Black	Hispanic	Other
PHR 1	5.7%	5.6%	7.1%	5.8%	2.4%
PHR 2	4.6%	5.2%	2.3%	3.4%	6.1%
PHR 3	4.6%	4.3%	5.5%	5.0%	1.9%
PHR 4	6.1%	6.2%	7.6%	4.4%	4.8%
PHR 5	4.1%	4.4%	4.7%	2.6%	2.1%
PHR 6	3.5%	4.5%	4.4%	2.7%	1.8%
PHR 7	3.4%	3.0%	3.7%	4.1%	1.5%
PHR 8	4.1%	4.7%	3.7%	3.8%	2.5%
PHR 9	2.6%	3.0%	1.3%	2.5%	0.0%
PHR 10	1.4%	1.8%	3.5%	1.3%	3.6%
PHR 11	2.9%	5.2%	4.1%	2.6%	1.8%
TEXAS	3.9%	4.4%	4.8%	3.4%	1.9%

5-Year Trend

	1998	2002
PHR 1	5.0%	5.7%
PHR 2	4.8%	4.6%
PHR 3	5.3%	4.6%
PHR 4	6.9%	6.1%
PHR 5	4.4%	4.1%
PHR 6	3.4%	3.5%
PHR 7	3.8%	3.4%
PHR 8	4.1%	4.1%
PHR 9	2.8%	2.6%
PHR 10	2.1%	1.4%
PHR 11	3.6%	2.9%
TEXAS	4.2%	3.9%

Race/Ethnicity & Age - 1998 & 2002

Race/ Ethnicity	1998	2002
White	4.7%	4.4%
Black	5.5%	4.8%
Hispanic	3.6%	3.4%
Other	2.1%	1.9%
Total	4.2%	3.9%

Age	1998	2002
13-17	5.3%	4.8%
18-19	4.7%	4.2%
20-24	4.0%	3.8%
25-34	4.0%	3.6%
35-44	4.5%	4.4%
45+	10.5%	8.4%
Total	4.2%	3.9%

Source : DSHS, Vital Statistics Unit, Natality Files, 1998 & 2002.

PHR - 2001 *

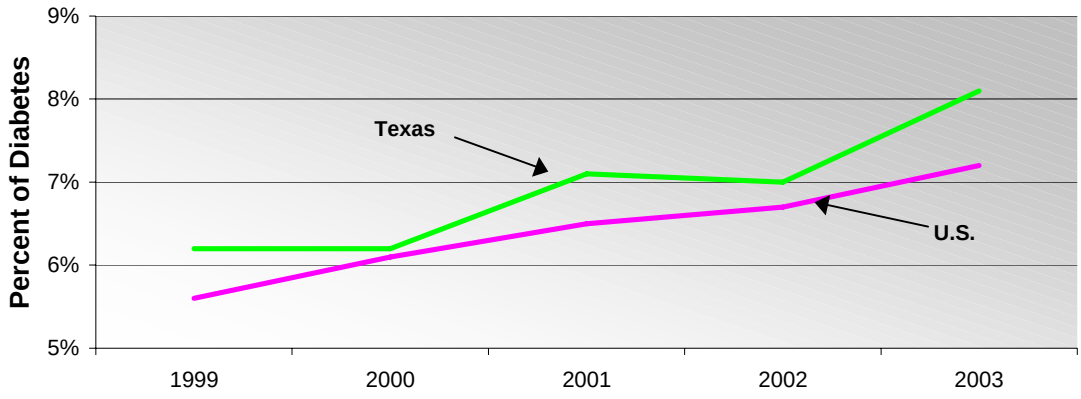
	Number	Percent
PHR 1	38,175	6.7%
PHR 2	26,653	6.5%
PHR 3	271,813	6.7%
PHR 4	51,164	6.7%
PHR 5	37,898	6.8%
PHR 6	246,402	7.0%
PHR 7	117,167	6.7%
PHR 8	111,370	7.1%
PHR 9	25,951	6.8%
PHR 10	37,453	7.6%
PHR 11	90,946	7.6%
TEXAS	1,055,002	6.2%

Race/ Ethnicity	**2003 ** ** Percent
White	7.7%
Black	10.9%
Hispanic	7.8%
Other	6.0%
TEXAS	8.1%

5-yr Rate Trend **

Texas vs. US Comparisons

	Texas Percent	U.S. (Median)
1999	6.2%	5.6%
2000	6.2%	6.1%
2001	7.1%	6.5%
2002	7.0%	6.7%
2003	8.1%	7.2%



The percent of diabetes for adults (ages 18+) increased in Texas and nationally from 1999 through 2003. However, the percent of diabetes in Texas was consistently higher than the national median for each year during this period. In Texas, the risk of diabetes was higher for black adults (10.9%) than for white (7.7%) or Hispanic (7.8%) or other (6.0%) adults.

Note: * PHR - 2001 was based on the DSHS, BRFSS report.
** Race/Ethnicity - 2003 and 5-yr Rate Trend were based on the CDC, BRFSS reports.

Source: DSHS, Behavioral Risk Factor Surveillance System (BRFSS), 2001;
CDC, Behavioral Risk Factor Surveillance System (BRFSS), 1999-2003.

Obesity Percentages for Women 18 and Over - *Women*

Public Health Administrative Region - 2002

	Percent
PHAR 1	24.7
PHAR 2/3	23.0
PHAR 4/5N	26.6
PHAR 6/5S	22.2
PHAR 7	24.4
PHAR 8	29.0
PHAR 9/10	24.4
PHAR 11	28.3
TEXAS	24.5

Race/Ethnicity & Age - 2002

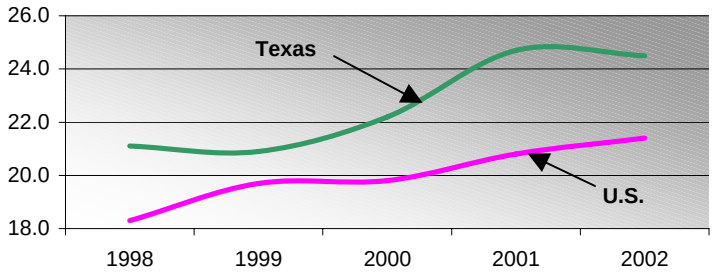
Race/ Ethnicity	Percent
White	21.0
Black	39.9
Hispanic	28.9
Total	24.5

Age	Percent
18-29	18.4
30-44	25.7
45-64	29.3
65+	21.6
Total	24.5

In 2002, 24.5% of women ages 18 and over in Texas were obese. The percentage for Black, at 39.9%, was highest, Hispanic following at 28.9% and White at 21.0% . Women aged 45-64 had the highest percentage at 29.3% with ages 30-44 falling second at 25.7%.

Texas vs. US Comparisons

	Texas	U.S.
1998	21.1	18.3
1999	20.9	19.7
2000	22.2	19.8
2001	24.7	20.8
2002	24.5	21.4



The percentage of obese women ages 18 and over in Texas increased each year from 21.1% in 1998 to 24.5% in 2002. The rate in Texas was consistently higher than the national average for each year.

Note: Percentages for obesity are calculated from respondents 18 years and older who report a Body Mass Index (BMI) of 30.0 or more. BMI is defined as weight in kilograms divided by height in meters squared (w/h**2).

Source: Texas Behavioral Risk Factor Surveillance System.
U.S. Behavioral Risk Factor Surveillance System.

Smoking - Women

Percentage of Smoking for Female *

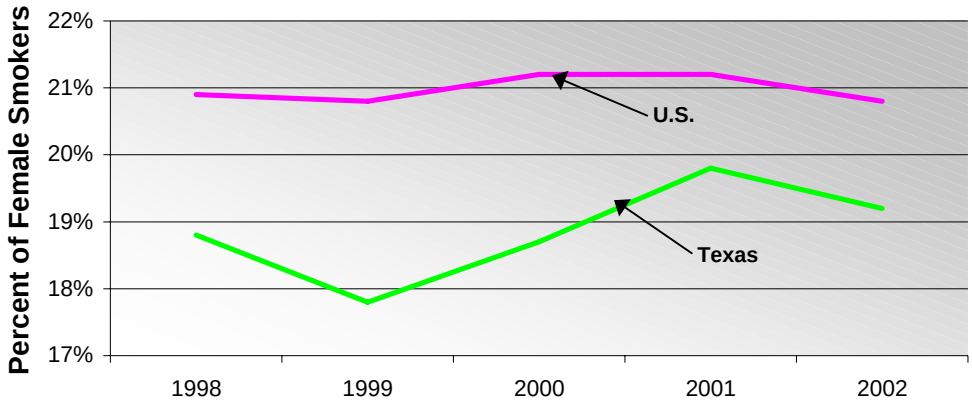
Texas vs. US Comparisons

	Texas Percent	U.S. (Median)
1998	18.8%	20.9%
1999	17.8%	20.8%
2000	18.7%	21.2%
2001	19.8%	21.2%
2002	19.2%	20.8%

Texas 2002

Race/ Ethnicity	Percent
White	21.4%
Black	17.7%
Hispanic	15.2%
Other	18.7%
TEXAS	19.2%

* Female respondents 18 and older who have ever smoked 100 cigarettes in their lifetime and reported smoking every day or some days.



The percent of females aged 18 years and over in Texas who ever smoked increased steadily from 17.8% in 1999 to 19.8% in 2001. For the last five years from 1998 - 2002 however, the percent of this age group who ever smoked in Texas was consistently lower than the US Median. Data for 2002 indicate that the percent of female smokers were highest among Whites (21.4%) and lowest among Hispanics (15.2%).

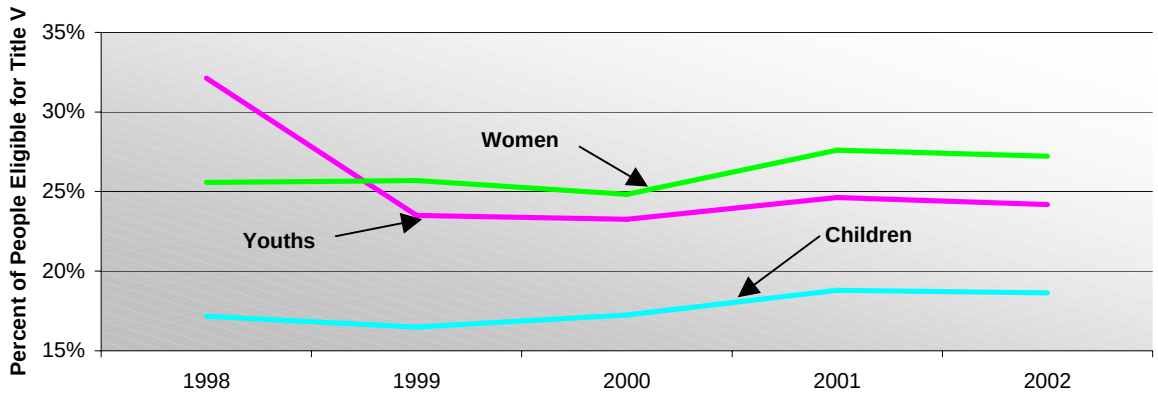
Source: CDC, Behavioral Risk Factor Surveillance System (BRFSS), 1998-2002.

Title V Eligible - *Children, Youths & Women*

PHR	Number of Children 1-12 Eligible for Title V					Percent of Children 1-12 Eligible for Title V				
	1998	1999	2000	2001	2002	1998	1999	2000	2001	2002
01	28,536	28,587	28,428	31,972	32,153	20.2%	20.6%	20.3%	22.9%	23.2%
02	19,280	19,035	19,008	19,917	19,847	21.2%	21.4%	21.3%	22.6%	22.7%
03	149,502	148,602	157,341	173,721	174,239	15.2%	14.8%	15.2%	16.3%	16.1%
04	30,718	29,940	32,137	36,088	35,726	18.9%	18.4%	19.0%	21.3%	21.1%
05	21,278	20,491	22,246	24,740	24,647	17.7%	17.1%	17.9%	20.0%	19.9%
06	143,287	135,886	148,398	168,205	168,882	15.7%	14.6%	15.7%	17.7%	17.5%
07	69,265	63,856	70,129	70,364	70,795	17.8%	16.2%	17.8%	17.5%	17.4%
08	76,197	75,441	78,047	82,973	82,858	19.1%	18.7%	19.3%	20.4%	20.3%
09	19,663	20,290	18,594	21,410	21,413	19.2%	20.4%	19.3%	22.7%	22.9%
10	35,155	36,422	32,626	34,905	35,429	21.1%	21.5%	21.7%	23.7%	24.1%
11	70,509	66,867	71,097	81,662	83,052	17.9%	16.6%	18.5%	21.2%	21.2%
TEXAS	663,390	645,417	678,049	745,956	749,040	17.2%	16.5%	17.2%	18.8%	18.6%

PHR	Number of Youths 13-21 Eligible for Title V					Percent of Youths 13-21 Eligible for Title V				
	1998	1999	2000	2001	2002	1998	1999	2000	2001	2002
01	42,832	30,902	32,788	35,226	35,350	36.0%	26.4%	27.5%	29.4%	29.6%
02	28,976	19,716	22,186	22,240	21,976	35.4%	24.3%	27.5%	27.6%	27.7%
03	160,939	129,665	141,739	151,625	150,441	24.7%	19.4%	19.8%	20.5%	19.9%
04	43,788	29,551	31,976	33,630	33,558	32.4%	21.9%	24.1%	24.9%	24.6%
05	33,205	22,341	24,224	25,759	26,050	32.0%	21.6%	24.0%	25.1%	25.1%
06	170,289	129,592	109,760	152,690	153,297	27.7%	20.6%	16.7%	22.5%	21.9%
07	112,647	77,946	94,940	87,694	84,769	33.0%	22.5%	26.7%	24.4%	23.8%
08	106,562	76,829	80,826	79,901	80,569	36.7%	26.1%	27.1%	26.0%	25.6%
09	29,692	21,672	21,138	23,345	23,907	35.9%	26.4%	26.8%	29.2%	29.8%
10	46,143	37,132	34,803	34,707	35,545	45.3%	36.8%	32.7%	31.7%	31.7%
11	116,750	84,978	82,752	88,900	90,799	46.2%	34.0%	31.0%	32.1%	31.7%
TEXAS	891,823	660,324	677,133	735,716	736,261	32.1%	23.5%	23.3%	24.6%	24.2%

PHR	Number of Women 19-44 Eligible for Title V					Percent of Women 19-44 Eligible for Title V				
	1998	1999	2000	2001	2002	1998	1999	2000	2001	2002
01	44,193	42,976	43,897	48,324	48,937	30.3%	29.9%	30.6%	33.6%	34.0%
02	29,623	27,549	28,135	30,035	30,306	30.4%	28.6%	30.5%	32.6%	33.1%
03	191,299	208,716	212,709	248,674	246,804	18.5%	20.0%	18.7%	21.3%	20.7%
04	49,270	45,717	48,051	52,421	52,476	28.1%	26.0%	28.2%	30.6%	30.5%
05	36,425	32,622	35,459	37,903	38,128	27.4%	24.5%	27.6%	29.6%	29.9%
06	196,164	204,125	184,149	251,108	250,438	21.5%	22.3%	18.7%	25.1%	24.5%
07	116,838	104,682	130,283	123,892	123,077	26.3%	23.3%	26.6%	24.6%	24.2%
08	121,067	117,083	121,582	123,622	123,951	29.9%	28.6%	30.1%	30.2%	29.9%
09	29,679	31,831	27,398	31,407	32,067	29.7%	32.5%	29.7%	34.3%	34.9%
10	53,654	61,385	53,267	57,619	58,317	38.4%	44.1%	38.7%	41.5%	41.4%
11	130,102	131,566	136,033	148,578	150,842	41.1%	41.3%	41.6%	44.4%	43.9%
TEXAS	998,314	1,008,252	1,020,962	1,153,582	1,155,342	25.6%	25.7%	24.8%	27.6%	27.2%



Source: DSHS, FCHS-R&PHA, K:\DATA\PIN, 1998-2002; UTSA, TX State Data Center, Epigram (Updated 09/2004).

Suicide Rate (Per 100,000) - *Children & Adults Age 5-44*

PHR - 2002

	Number	Rate/100,000
PHR 1	61	13.2
PHR 2	32	10.4
PHR 3	310	8.4
PHR 4	76	13.4
PHR 5	46	11.0
PHR 6	337	10.5
PHR 7	153	10.0
PHR 8	112	8.5
PHR 9	42	13.8
PHR 10	30	6.7
PHR 11	78	6.9
TEXAS	1277	9.6

5-Year Trend

	Rate/100,000	
PHR 1	15.5	13.2
PHR 2	14.4	10.4
PHR 3	9.7	8.4
PHR 4	13.3	13.4
PHR 5	12.6	11.0
PHR 6	10.3	10.5
PHR 7	10.6	10.0
PHR 8	9.3	8.5
PHR 9	12.8	13.8
PHR 10	5.6	6.7
PHR 11	6.4	6.9
TEXAS	10.2	9.6

Race/Ethnicity - 2002

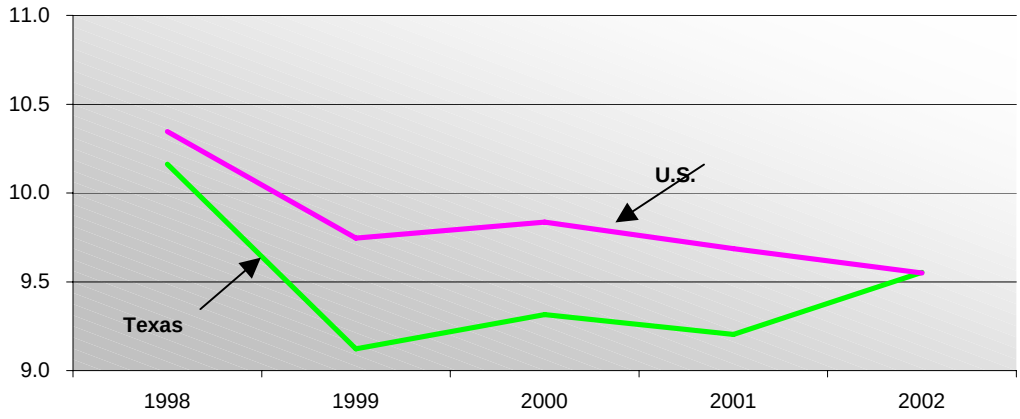
	#	Rate
White	887	14.4
Black	93	5.6
Hispanic	276	5.4
Other	21	4.1
Total	1,277	9.6

Age - 2002

	#	Rate
5-14	24	0.7
15-24	322	9.6
25-34	401	12.2
35-44	530	15.7
Total	1,277	9.6

Texas vs. US Comparisons

	Texas	U.S.
1998	10.2	10.3
1999	9.1	9.7
2000	9.3	9.8
2001	9.2	9.7
2002	9.6	9.5



In Texas, the suicide rate dropped to 9.6 in 2002 compared to 10.2 in 1998. In 2002, whites had the highest suicide rate (14.4); the suicide rate increased with age and was highest for the age group with 35-44 (15.7). The suicide rate in Texas was lower than the national average for each year during 1998-2001, and slightly higher in 2002.

Source: DSHS, Vital Statistics Unit, Mortality Files; CDC, NCHS, National Vital Statistics Reports, 1998-2002; UTSA, TX State Data Center, Epigram (Updated 09/2004).

C H I L D R E N

A D O L E S C E N T S

Teen Pregnancy Rate - *Adolescents*

PHR - 2002
Pregnancies

	All Ages	Age 13-17	% 13-17
PHR 1	13,888	949	6.8%
PHR 2	8,060	553	6.9%
PHR 3	123,445	5,496	4.5%
PHR 4	15,699	940	6.0%
PHR 5	11,413	672	5.9%
PHR 6	109,429	4,822	4.4%
PHR 7	48,679	2,041	4.2%
PHR 8	45,253	2,761	6.1%
PHR 9	9,097	715	7.9%
PHR 10	16,502	1,065	6.5%
PHR 11	46,099	3,128	6.8%
TEXAS	447,564	23,311	5.2%

5-Year Trend
Pregnancy Rate 13-17 Yr olds

	1998	2002
PHR 1	39.8	32.2
PHR 2	35.1	27.8
PHR 3	33.3	26.0
PHR 4	34.5	25.1
PHR 5	32.8	24.6
PHR 6	33.9	25.0
PHR 7	33.3	25.1
PHR 8	38.7	31.7
PHR 9	42.7	33.0
PHR 10	36.9	34.4
PHR 11	45.1	39.6
TEXAS	36.2	28.5

Race/Ethnicity & Age, 13-17 Yr Olds - 2002

Race/ Ethnicity	Number	Rate
White	5,191	14.1
Black	3,778	34.8
Hispanic	14,053	44.6
Other/unknown	289	11.1
Total	23,311	28.5

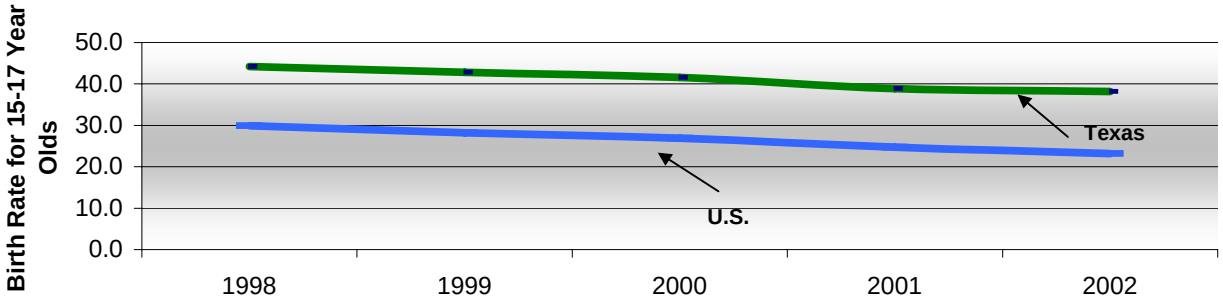
Age	Number	Rate
13	203	1.2
14	1,039	6.3
15	3,176	19.5
16	7,180	43.8
17	11,713	71.7
Total	23,311	28.5

Texas vs. US Comparisons
Live Births - 15-17 Yr Olds

	TX #	Rate/1,000 Texas	U.S.
1998	26,627	44.2	29.9
1999	26,117	42.8	28.2
2000	24,665	41.6	26.9
2001	23,416	38.9	24.7
2002	22,069	38.2	23.2

Pregnancy rates are the combination of live births, fetal deaths and abortions.

Births to 15-17 year olds in Texas declined 14% from 1998 to 2002, while the national decline was 22%. In 2002 births to this age group were 39% higher in Texas than in the nation.



In 2002, teen pregnancies to females aged 13 - 17 accounted for 5.2% of all pregnancies and 6.2% of all live births in Texas. The largest numbers of teen pregnancies were reported in Region 3 (Dallas/Ft Worth area) , Region 6 (Houston area) and Region 11 (Harlingen and the TX-Mexico border). Of these three regions, only Region 11 had a higher percentage of teen pregnancies as a part of all pregnancies than the statewide average of 5.2%. Teen pregnancy rates declined 27% overall from 1998 to 2002. The higest decreases were seen in Regions 4, 5, 6 and 7; all with decreases over 30%. Region 11 had the highest teen pregnancy rate in 1998 at 45.1, and remained highest in 2002, with a 14% decrease.

Source: DSHS, Vital Statistics Unit, Natality Files; National Vital Statistics Report, December 17, 1998 -2002.

Confirmed Victims of Child Abuse and/or Neglect for Ages 0-17 - *Children*

Public Health Region - 2004

	All	White	Black	Hispanic	Other
PHR 1	15.1	405	1,267	1,454	76
PHR 2	14.8	266	423	1,274	54
PHR 3	7.9	3,541	3,150	5,671	433
PHR 4	10.7	622	286	1,779	68
PHR 5	8.6	544	94	945	32
PHR 6	6.1	2,898	2,759	2,955	293
PHR 7	10.6	1,471	2,148	2,838	164
PHR 8	7.6	482	3,177	969	84
PHR 9	9.3	152	636	550	22
PHR 10	3.7	55	663	106	17
PHR 11	9.3	166	4,892	543	77
TEXAS	8.3	10,602	19,495	19,084	1,320

5-Year Trend

	1998	2004
PHR 1	11.2	15.1
PHR 2	11.8	14.8
PHR 3	6.9	7.9
PHR 4	9.5	10.7
PHR 5	11.9	8.6
PHR 6	6.7	6.1
PHR 7	9.1	10.6
PHR 8	8.6	7.6
PHR 9	6.4	9.3
PHR 10	7.1	3.7
PHR 11	7.0	9.3
TEXAS	7.8	8.3

Race/Ethnicity & Age - 2004

Race/ Ethnicity	Number	Rate
White	19,094	7.6
Black	10,606	13.8
Hispanic	19,507	7.5
Other	1,322	6.7
Total	50,529	8.3

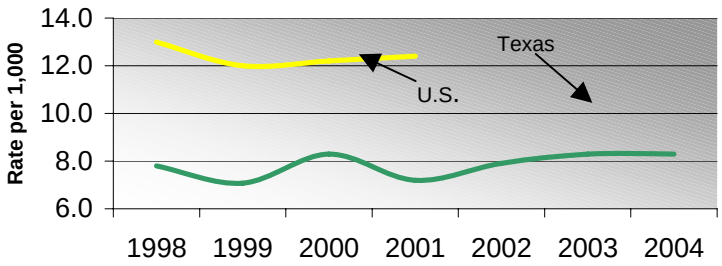
Age	Number	Rate
<1	6,836	19.3
1-3	11,637	11.0
4-6	10,166	10.4
7-9	7,813	8.0
10-12	6,525	6.4
13-17	7,397	4.4
Unknown	155	
Total	50,529	8.3

In 2004, the incidence rate of confirmed victims of child abuse and/or neglect for ages 0-17 was 8.3. The incidence rate was highest among blacks at 13.8, followed by Whites at 7.6 and Hispanics at 7.5. Infants age <1 year had the highest rate at 19.3, with incidence rates decreasing as age increased. The total number of confirmed victims of child abuse and/or neglect in Texas was 50,529 in 2004.

Texas vs. US Comparisons

	Texas	U.S.
1998	7.8	13.0
1999	7.1	12.0
2000	8.3	12.2
2001	7.2	12.4
2002	7.9	NA
2003	8.3	NA
2004	8.3	NA

Victims 0-17 Years of Age



The rate of confirmed victims of child abuse and/or neglect for children ages 0-17 in Texas has fluctuated between 7.1 and 8.3 each year from 1998 through 2003. The rate for Texas is consistently lower than the national average.

Note:
Rate per 1,000 population for ages 0-17.
Source: DFPS, Forcasting and Program Statistics, CAPS, 1998 - 2004.
Child Welfare League of America, National Data Analysis System.
UTSA, TX State Data Center, Epigram (Updated 09/2004).

Deaths to Children Ages 1-14 - *Children*

PHR - 2002

	All	White	Black	Hispanic
PHR 1	23.4	22.8	45.7	20.6
PHR 2	27.2	26.8	53.1	20.2
PHR 3	22.3	19.3	33.5	22.0
PHR 4	39.0	42.3	31.1	34.6
PHR 5	30.9	33.4	24.5	31.6
PHR 6	21.4	18.0	34.5	19.0
PHR 7	21.9	17.5	26.9	27.8
PHR 8	23.8	24.8	27.0	22.9
PHR 9	22.6	24.3	18.3	21.6
PHR 10	19.7	4.8	62.7	20.5
PHR 11	23.2	22.8	19.2	23.3
TEXAS	23.3	21.7	32.5	22.3

5-Year Trend

	1998	2002
PHR 1	25.4	23.4
PHR 2	25.2	27.2
PHR 3	20.2	22.3
PHR 4	44.0	39.0
PHR 5	39.7	30.9
PHR 6	22.3	21.4
PHR 7	30.1	21.9
PHR 8	22.7	23.8
PHR 9	23.2	22.6
PHR 10	22.2	19.7
PHR 11	20.3	23.2
TEXAS	24.1	23.3

Race/Ethnicity & Age - 2002

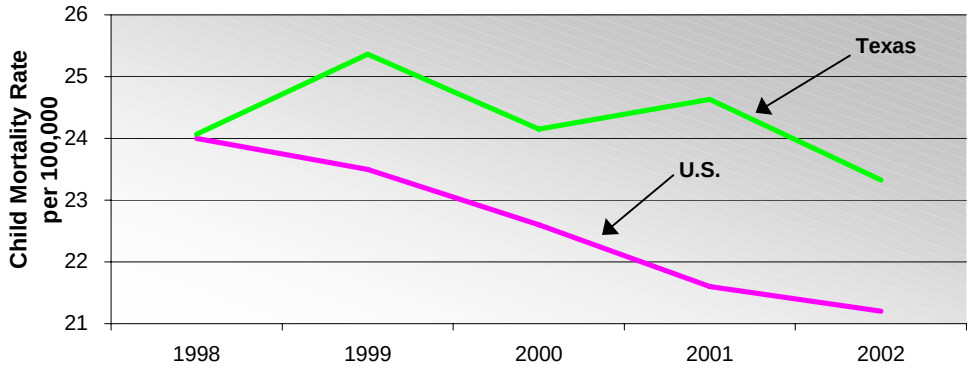
Race/ Ethnicity	#	Rate
White	456	21.7
Black	198	32.5
Hispanic	440	22.3
Total	1,094	23.3

Age	#	Rate
1-4	457	34.3
5-9	262	15.9
10-14	375	22.0
Total	1,094	23.3

Texas vs. US Comparisons

	Texas	U.S.
1998	24.1	24.0
1999	25.4	23.5
2000	24.2	22.6
2001	24.6	21.6
2002	23.3	21.2

Death rates for children ages 1-14 in Texas was highest in 1999 at 25.4 and lowest in 2002 at 23.3. Nationally, the rate of deaths to children ages 1-14 decreased from 1998 through 2002. The child death rate in Texas was consistently higher than the national average for each year during 1998-2002.



There were 1,094 child deaths to Texas residents ages 1-14 in 2002, for a mortality rate of 23.3 per 100,000 population. Black children in Texas had higher mortality rate (32.5) than white children (21.7) or Hispanic children (22.3). The Texas death rate for children 1-14 years of age was dramatically higher in the 1-4 year old age group (34.3) than the 5-9 or 10-14 year old age groups which were 15.9 and 22.0, respectively.

Note: Rate per 100,000 population.

Source: DSHS, Vital Statistics Unit, Mortality Files; CDC, NCHS, National Vital Statistics Reports, 1998-2002; UTSA, TX State Data Center, Epigram (Updated 09/2004).

Fatal Unintentional Injury Rates * from Motor Vehicles to Children Ages 1-12 - *Children*

Region - 2002

	All	White	Black	Hispanic
PHR 1	7.9	10.2	21.3	3.4
PHR 2	3.4	5.2	0.0	0.0
PHR 3	4.5	4.5	7.2	3.4
PHR 4	12.4	12.8	6.1	19.8
PHR 5	7.3	5.5	3.2	18.1
PHR 6	4.2	3.0	6.8	4.3
PHR 7	5.9	2.8	7.0	10.3
PHR 8	4.2	3.2	0.0	5.2
PHR 9	4.3	5.0	21.7	2.1
PHR 10	4.1	0.0	0.0	4.8
PHR 11	4.6	2.4	0.0	5.0
TEXAS	5.1	4.6	6.6	5.1

5-Year Trend

	1998	2002
PHR 1	7.8	7.9
PHR 2	4.4	3.4
PHR 3	3.6	4.5
PHR 4	9.2	12.4
PHR 5	10.8	7.3
PHR 6	4.5	4.2
PHR 7	6.9	5.9
PHR 8	5.0	4.2
PHR 9	4.9	4.3
PHR 10	4.2	4.1
PHR 11	6.4	4.6
TEXAS	5.3	5.1

Race/Ethnicity & Age - 2002

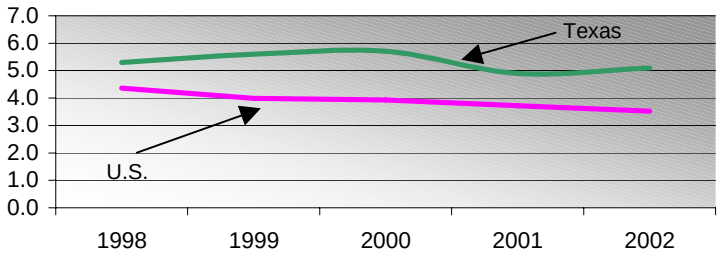
Race/ Ethnicity	#	Rate
White	76	4.6
Black	34	6.6
Hispanic	87	5.1
Total *	203	5.1

Age	#	Rate
1-4	80	6.0
5-9	81	4.9
10-12	42	4.1
Total	203	5.1

In 2002, Texas residents ages 1-12 had 203 fatalities from motor vehicle accidents with a death rate of 5.1. The rate for Blacks, at 6.6, was highest, Hispanics following at 5.1, and Whites at 4.6. Children ages 1-4 had the highest number of motor vehicle deaths at 80 (6.0), ages 5-9 falling second at 81 (4.9), and ages 10-12 had a total of 42 fatalities (4.1).

Texas vs. US Comparisons

	Texas	U.S.
1998	5.3	4.4
1999	5.6	4.0
2000	5.7	3.9
2001	4.9	3.7
2002	5.1	3.5



Motor vehicle mortality rate for Texans ages 1-12 increased each year from 5.3 in 1998 to 5.7 in 2000. There was a sharp decrease in rate to 4.9 in 2001, then a slight increase to 5.1 in 2002. The Texas motor vehicle mortality rate was consistently higher than the national average.

Note:

Rate per 100,000 population for ages 1-12.

* Texas totals include those with unknown county of residence.

Source: DSHS, Vital Statistics Unit, Fatality Files, 1998 - 2002.
TAMU, Texas State Data Center, September 2004.

Fatal Unintentional Injury Rates * from Motor Vehicles to Children Ages 13-19 - *Children*

Region - 2002

	All	White	Black	Hispanic
PHR 1	22.4	30.3	0.0	15.3
PHR 2	28.1	29.0	62.0	15.1
PHR 3	21.9	23.7	20.8	20.5
PHR 4	50.5	58.6	19.8	49.2
PHR 5	39.8	56.0	10.0	11.5
PHR 6	22.4	25.1	17.4	24.4
PHR 7	25.3	28.4	3.0	28.3
PHR 8	24.4	33.7	19.5	19.5
PHR 9	20.6	26.3	0.0	17.4
PHR 10	12.5	0.0	0.0	14.8
PHR 11	20.9	21.3	0.0	21.3
TEXAS	24.2	29.7	16.6	21.4

5-Year Trend

	1998	2002
PHR 1	28.8	22.4
PHR 2	27.0	28.1
PHR 3	20.4	21.9
PHR 4	47.6	50.5
PHR 5	48.2	39.8
PHR 6	19.0	22.4
PHR 7	27.0	25.3
PHR 8	22.4	24.4
PHR 9	27.5	20.6
PHR 10	17.6	12.5
PHR 11	24.0	20.9
TEXAS	24.4	24.2

Race/Ethnicity & Age - 2002

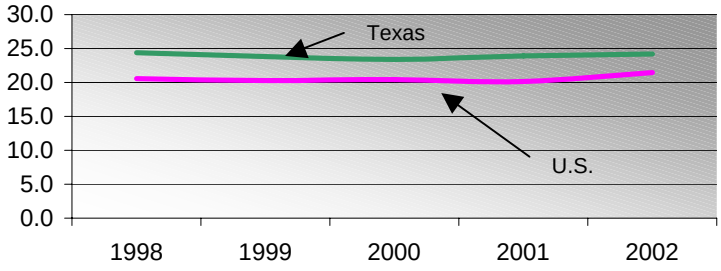
Race/ Ethnicity	#	Rate
White	314	29.7
Black	51	16.6
Hispanic	196	21.4
Total*	572	24.2

Age	#	Rate
13-14	56	8.3
15-16	125	18.7
17-18	265	39.4
19	126	36.5
Total	572	24.2

In 2002, Texas residents ages 13-19 had 572 fatalities from motor vehicle accidents with a death rate of 5.3. The rate for Whites, at 29.7, was highest, Hispanics followed at 21.4, and Blacks at 16.6. Teenagers 17-18 years had the highest number of motor vehicle deaths at 265 (39.4); teens 19 years of age at the second highest number of fatalities at 126 (36.5) and those 15-16 years, the third highest at 125 fatalities (18.7).

Texas vs. US Comparisons

	Texas	U.S.
1998	24.4	20.6
1999	23.8	20.3
2000	23.4	20.4
2001	23.9	20.1
2002	24.2	21.5



The motor vehicle mortality rate for Texans ages 13-19 decreased each year from 24.4 in 1998 to 23.4 in 2000. In 2001 and 2002, there was an increase in the rate, from 23.9 to 24.2. The motor vehicle mortality rate in Texas was consistently higher than the national average.

Note:

Rate per 100,000 population for ages 13-19.

* Texas totals include those with unknown county of residence.

Source: DSHS, Vital Statistics Unit, Fatality Files, 1998 - 2002.
TAMU, Texas State Data Center, September 2004.

Homicide - *Children & Adults*

PHR - 2002

	Children (1-14)		Adults (25+)	
	#	Rate/10,000	#	Rate/10,000
PHR 1	2	1.2	17	3.6
PHR 2	3	2.9	13	3.7
PHR 3	17	1.3	267	7.3
PHR 4	2	1.0	61	9.0
PHR 5	5	3.4	31	6.4
PHR 6	23	2.0	277	8.8
PHR 7	6	1.3	58	3.9
PHR 8	10	2.1	102	7.4
PHR 9	2	1.8	11	3.4
PHR 10	3	1.7	17	4.1
PHR 11	5	1.1	67	6.5
TEXAS	78	1.7	921	6.9

5-Year Trend

	Children (1-14)		Adults (25+)	
	1998	2002	1998	2002
	Rate/10,000		Rate/10,000	
PHR 1	1.8	1.2	5.6	3.6
PHR 2	0.0	2.9	6.4	3.7
PHR 3	1.7	1.3	8.2	7.3
PHR 4	4.7	1.0	8.4	9.0
PHR 5	2.1	3.4	8.6	6.4
PHR 6	1.0	2.0	9.4	8.8
PHR 7	2.2	1.3	5.1	3.9
PHR 8	0.6	2.1	7.2	7.4
PHR 9	0.0	1.8	4.0	3.4
PHR 10	0.0	1.7	3.3	4.1
PHR 11	1.3	1.1	7.8	6.5
TEXAS	1.4	1.7	7.6	6.9

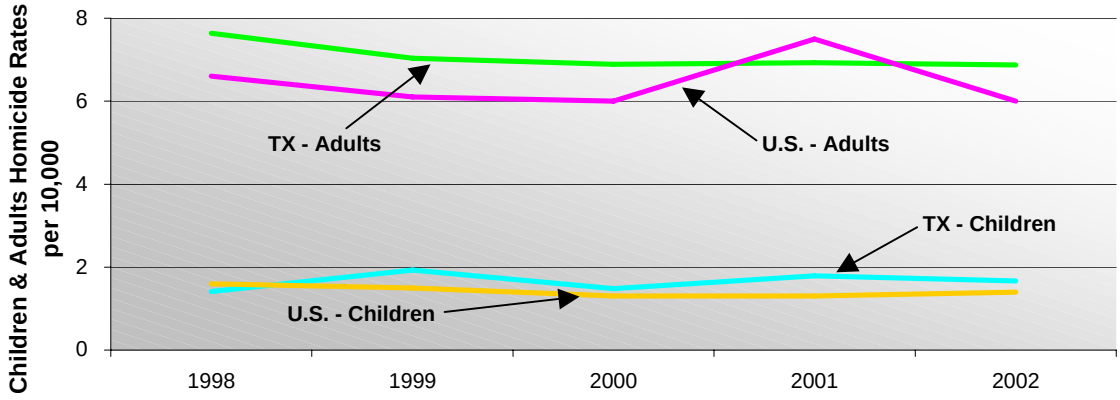
Race/Ethnicity - 2002

Race/	Children (1-14)		Adults (25+)	
Ethnicity	#	Rate/10,000	#	Rate/10,000
White	25	1.3	297	3.9
Black	27	4.4	292	20.2
Hispanic	24	1.2	304	8.0
Other	2	1.3	28	5.7
Total	78	1.7	921	6.9

Texas vs. US Comparisons

	Children (1-14)		Adults (25+)	
	Texas	U.S.	Texas	U.S.
1998	1.4	1.6	7.6	6.6
1999	1.9	1.5	7.0	6.1
2000	1.5	1.3	6.9	6.0
2001	1.8	1.3	6.9	7.5
2002	1.7	1.4	6.9	6.0

In Texas, the child homicide rate fluctuated from 1998 through 2002, and the adult homicide rate decreased from 1998 to 2000 and then remained unchanged through 2002. Nationally, the child homicide rate decreased from 1998 through 2001, and the adult homicide rate showed a decreasing trend, except for 2001. On average during 1998-2002, the homicide rate in Texas was higher than the national homicide rate for both children and adults.



In Texas, there were 78 homicide deaths to children ages 1-14 in 2002, for a homicide rate of 1.7 per 10,000 population. In 2002, there were 921 homicide deaths to adults aged 25 years or more and a drop in the homicide rate (6.9 vs. 7.6) compared with 1998. Black children and adults had much higher homicide rates than white or Hispanic or other children and adults.

Source: DSHS, Vital Statistics Unit, Mortality Files; CDC, NCHS, National Vital Statistics Reports, 1998-2002; UTSA, TX State Data Center, Epigram (Updated 09/2004).

PHR - 2002

	Children (5-14)		Youths (15-24)	
	#	Rate/10,000	#	Rate/10,000
PHR 1	1	0.9	14	10.4
PHR 2	2	2.7	7	7.8
PHR 3	5	0.6	66	8.0
PHR 4	2	1.4	21	14.5
PHR 5	1	0.9	13	11.5
PHR 6	5	0.6	92	12.2
PHR 7	0	0.0	38	8.7
PHR 8	4	1.2	30	9.0
PHR 9	3	3.7	13	15.3
PHR 10	0	0.0	5	4.2
PHR 11	1	0.3	23	7.6
TEXAS	24	0.7	322	9.6

5-Year Trend

	Children (5-14)		Youths (15-24)	
	1998	2002	1998	2002
	Rate/10,000		Rate/10,000	
PHR 1	0.0	0.9	16.6	10.4
PHR 2	1.3	2.7	15.4	7.8
PHR 3	0.5	0.6	12.9	8.0
PHR 4	2.9	1.4	11.9	14.5
PHR 5	0.0	0.9	8.6	11.5
PHR 6	0.8	0.6	13.3	12.2
PHR 7	1.6	0.0	10.0	8.7
PHR 8	0.3	1.2	8.1	9.0
PHR 9	1.1	3.7	10.1	15.3
PHR 10	0.0	0.0	7.9	4.2
PHR 11	1.0	0.3	8.8	7.6
TEXAS	0.8	0.7	11.5	9.6

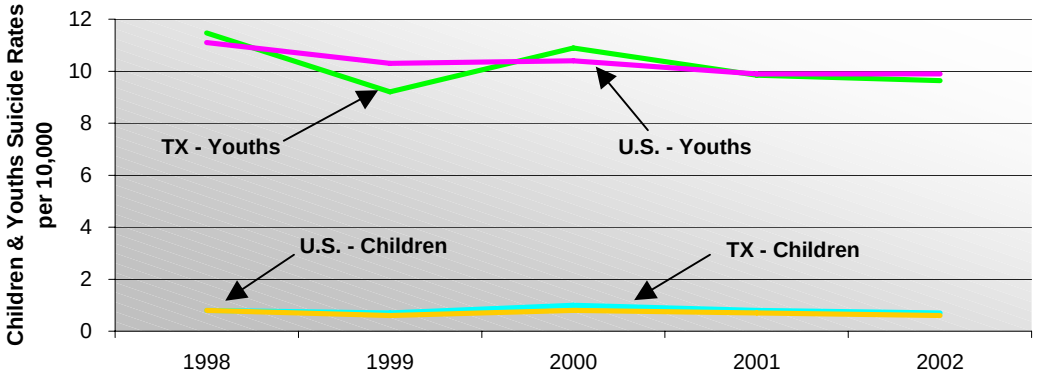
Race/Ethnicity - 2002

Race/	Children (5-14)		Youths (15-24)	
Ethnicity	#	Rate/10,000	#	Rate/10,000
White	12	0.8	197	13.4
Black	2	0.4	22	5.2
Hispanic	8	0.6	98	7.3
Other	2	1.9	5	4.5
Total	24	0.7	322	9.6

Texas vs. US Comparisons

	Children (5-14)		Youths (15-24)	
	Texas	U.S.	Texas	U.S.
1998	0.8	0.8	11.5	11.1
1999	0.7	0.6	9.2	10.3
2000	1.0	0.8	10.9	10.4
2001	0.8	0.7	9.8	9.9
2002	0.7	0.6	9.6	9.9

In Texas, the suicide rate for children (5-14) and youths (15-24) fluctuated from 1998 through 2000, and then decreased from 2000 through 2002. Nationally, the suicide rate showed a steady trend for children (5-14) and a decreasing trend for youths (15-24) from 1998 through 2002. The suicide rates for children in Texas were slightly higher than national averages for each year from 1999 to 2002.



In Texas, there were 24 suicide deaths to children ages 5-14 in 2002, for a suicide rate of 0.7 per 10,000 population. With 322 suicide deaths to youths ages 15-24 in 2002, the suicide rate dropped to 9.6 in 2002 compared to 11.5 in 1998. White children and youths had higher suicide rate than black or Hispanic children and youths.

Source: DSHS, Bureau of Vital Statistics, Mortality; CDC, NCHS, National Vital Statistics Reports, 1998-2002; UTSA, TX State Data Center, Epigram (Updated 09/2004).

Smoking - Children: Student Grades 9-12

Percentage of Smoking for Children ** in 2001

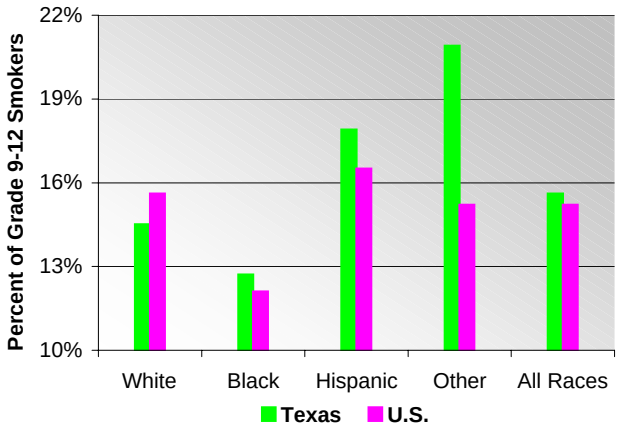
Race/ Ethnicity	Grade 9	Grade 10	Grade 11	Grade 12	Total
White	12.5%	15.5%	17.0%	14.3%	14.5%
Black	8.6%	13.5%	17.3%	12.4%	12.7%
Hispanic	17.1%	17.0%	18.2%	19.2%	17.9%
Other	N/A	N/A	N/A	N/A	20.9%
TEXAS	13.6%	16.0%	17.5%	15.9%	15.6%

In 2001, smoking was highest overall among Grade 11 students, with a steady increase in the percent of smokers in all ethnic groups from Grade 9 throught 11, followed by an overall decline in Grade 12. Smoking was highest among Hispanic students in all Grades, and increased consistently from Grade 9 through Grade 12.

Texas vs. US Comparisons

Race/ Ethnicity	Texas	U.S.
White	14.5%	15.6%
Black	12.7%	12.1%
Hispanic	17.9%	16.5%
Other	20.9%	15.2%
All Races	15.6%	15.2%

** Grade 9-12 students who smoked cigars, cigarillos, or little cigars on one or more of the past 30 days.



In 2001, Smoking among students in Texas was slightly higher than the national average (15.6% vs. 15.2%). Except for white students, smoking among Texas students for all other ethnic groups was higher than the national average.

Source: CDC, Youth Risk Behavior Surveillance System (YRBSS), 2001.

Overweight* Percentages for Ages 14 through 18 - *Adolescence*

3-Year Trend

	1999~	2001"	2003^
TEXAS	10.5	14.2	13.9

Race/Ethnicity, Grade & Age

Race/Ethnicity	1999~	2001'	2003^
White, Non-Hispanic	8.5	10.9	11.1
African-American, Non-Hispanic	16.8	17.3	16.3
Hispanic/Latino	10.4	17.6	16.5
All Other	n.a.	4.8	10.4
Total	10.5	14.2	13.9

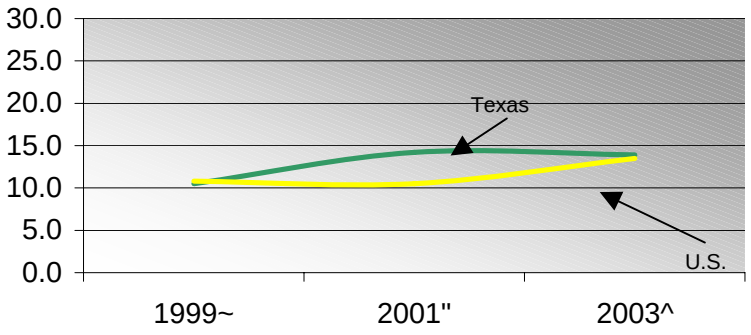
Age	1999~	2001	2003^
14	n.a.	9.8	20.6
15	n.a.	12.7	15.2
16	n.a.	13.9	11.7
17	n.a.	12.1	14.7
18+	n.a.	16.2	9.8
Total	10.5	14.2	13.9

Grade	1999~	2001"	2003^
9th	9.1	12.5	17.5
10th	9.8	16.2	14.3
11th	13.5	13.4	10.6
12th	8.8	15.5	11.8
Total	10.5	14.2	13.9

The percentage of overweight adolescents age 14 through 18 increased between 1999 (10.5%) and 2001 (14.2%) and has shown a slight decrease in 2003 (13.9). Adolescents of Hispanic origin had the highest percentage in both 2001(17.6%) and 2003 (16.5) and Whites the lowest in all years (1999-2003). African Americans had the highest percentage (16.8) in 1999. In 2001, adolescents age 18 and over had the highest percentage and those age 14 the lowest; in 2003, the opposite was true.

Texas vs. US Comparisons

	Texas	U.S.
1999~	10.5	10.8
2001"	14.2	10.5
2003^	13.9	13.5



The percentage of adolescents ages 14 through 18 who were overweight has increased each year for Texas.

Note:

~ Unweighted data.

" Weighted data.

^ Weighted data excluding Houston ISD.

Percentages for overweight are calculated from self-reported data for height and weight.

Individuals with Body Mass Index (BMI) at the 95th percentile and above are classified as overweight.

BMI is defined as weight in kilograms divided by height in meters squared (w/h**2)

Source: Texas Youth Behavioral Risk Survey, 1999 - 2003.
National Youth Behavioral Risk Survey, 1999 - 2003.

Obesity - *WIC Children (Age 1-4)*

PHR - 2005*

	All	White	Black	Hispanic	Other
PHR 1	9.8%	6.9%	8.3%	11.0%	5.5%
PHR 2	8.6%	6.8%	7.1%	11.2%	4.3%
PHR 3	9.3%	6.7%	6.4%	10.8%	6.9%
PHR 4	11.1%	8.7%	9.7%	15.2%	8.8%
PHR 5	9.4%	8.1%	8.0%	12.8%	10.2%
PHR 6	10.6%	7.3%	6.7%	12.0%	6.3%
PHR 7	9.0%	6.6%	6.8%	10.6%	6.1%
PHR 8	11.0%	7.8%	7.7%	11.6%	10.9%
PHR 9	6.9%	4.1%	5.2%	7.9%	0.0%
PHR 10	8.7%	6.0%	8.7%	8.8%	16.7%
PHR 11	11.9%	11.4%	12.6%	11.9%	4.9%
TEXAS	10.3%	7.3%	7.1%	11.4%	6.8%

3-Year Trend

	2003*	2004*	2005*
PHR 1	10.2%	9.4%	9.8%
PHR 2	10.8%	9.1%	8.6%
PHR 3	9.6%	8.9%	9.3%
PHR 4	10.1%	9.9%	11.1%
PHR 5	9.9%	10.0%	9.4%
PHR 6	12.4%	10.4%	10.6%
PHR 7	10.2%	8.8%	9.0%
PHR 8	11.4%	10.2%	11.0%
PHR 9	9.2%	8.0%	6.9%
PHR 10	8.3%	7.7%	8.7%
PHR 11	11.4%	11.3%	11.9%
TEXAS	10.8%	9.8%	10.3%

The figures are based on the WIC data for the risk code 113 (child overweight) which is defined as body mass index (BMI) at or above the age-specific 95th percentile BMI.

In Texas 2005, the prevalence of obesity was much higher for Hispanic children (11.4%) than for white (7.3%) or black (7.1%) or other (6.8%) children.

Source : DSHS, Bureau of Nutrition Services, 2003-2005 Annual Nutritional Risk Reports (* State Fiscal Year).

Oral Health Screen - *Children*

Percent of Children Ages 1-14 Receiving Dental Services

	PHR - 2003 # w/ Services		Eligibles	2003 %
	1998	2003	2003	w/ Services
PHR 1	16,714	22,547	70,778	0.32
PHR 2	11,575	16,248	41,613	0.39
PHR 3	75,380	159,912	375,326	0.43
PHR 4	21,048	30,250	82,942	0.36
PHR 5	18,498	23,014	64,458	0.36
PHR 6	139,459	197,285	381,647	0.52
PHR 7	34,745	50,450	148,148	0.34
PHR 8	68,652	104,025	204,449	0.51
PHR 9	11,497	15,426	49,825	0.31
PHR 10	39,726	49,579	100,127	0.50
PHR 11	120,070	164,990	295,502	0.56
TEXAS	557,364	833,726	1,771,022	0.47

	5-yr Trend % w/ Services	
	1998	2003
PHR 1	0.27	0.32
PHR 2	0.33	0.39
PHR 3	0.32	0.43
PHR 4	0.34	0.36
PHR 5	0.34	0.36
PHR 6	0.52	0.52
PHR 7	0.32	0.34
PHR 8	0.39	0.51
PHR 9	0.28	0.31
PHR 10	0.46	0.50
PHR 11	0.47	0.56
TEXAS	0.40	0.47

Race/Ethnicity & Age - 2002*

Race/ Ethnicity	all ages	% of recipients
White	723,285	24%
Black	533,579	18%
Hispanic	1,465,561	50%
Other	230,144	8%
Total	2,952,569	100%

Age	#	% of recipients
<1	195,738	7%
1-5	697,442	24%
6-14	697,132	24%
15-20	295,640	10%
21+	1,066,304	36%
Total	2,952,256	100%

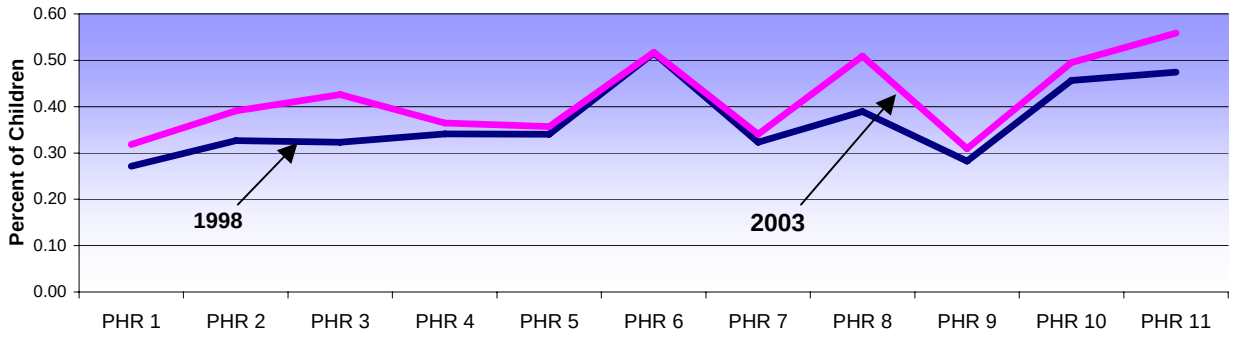
*CMS MSIS 2002, All Texas Medicaid Recipients.

Children 1-14 in the Texas Health Steps Medicaid program are recommended to have 2 prophylactic dental exams each year, with additional preventive treatments such as sealants, and treatments for dental problem (caries, etc.) as required.

The ratio of THSteps children 1-14 with dental services to eligibles 1-14 gives a perspective of dental services usage, but should not be confused with a participation rate. A participation rate takes into account the schedule and the length of program stay of participants.

In the U.S. summary for 1998, the latest available EPSDT summary, the percentage of U.S children aged 1-14 receiving dental assessments (preventive exams and/or sealants) was 22.4% , compared to 37.5% in Texas.

Children 1-14 Receiving Dental Services



The number of children age 1-14 receiving dental services in Texas increased from 557,364 to 833,726 from 1998 to 2003, a 50% increase. The percentage of children receiving services during those five years increased in every region, except PHR6, which remained at 52%. PHR6 had the highest percentage of children receiving dental services in 1998 (52%) and the second highest percentage in 2003, surpassed only by PHR11, which increased to 56%.

Sources: NHIC, HMPR980K 1998; TMHP, HISR303A 2003; CMS MSIS 2002; TX HCFA-416 1998 and US HCFA-416 1998.

Medicaid Checkups for Children 1-14 - *Children*

Percent of Expected Children Receiving a THSteps Checkup

	PHR - 2003 # with Checkups		Expected	2003 %
	1998	2003	2003	Expected
PHR 1	18,848	26,105	49,707	0.53
PHR 2	11,996	16,945	29,948	0.57
PHR 3	70,035	153,297	266,086	0.58
PHR 4	22,685	37,553	59,744	0.63
PHR 5	19,495	24,854	46,592	0.53
PHR 6	100,189	159,343	278,873	0.57
PHR 7	26,160	50,844	106,063	0.48
PHR 8	52,037	80,113	147,395	0.54
PHR 9	13,391	20,523	36,147	0.57
PHR 10	35,819	40,534	72,781	0.56
PHR 11	126,654	169,418	221,817	0.76
TEXAS	497,309	785,529	1,302,018	0.60

	5-yr Trend % Expected	
	1998	2003
PHR 1	0.47	0.53
PHR 2	0.48	0.57
PHR 3	0.44	0.58
PHR 4	0.56	0.63
PHR 5	0.48	0.53
PHR 6	0.59	0.57
PHR 7	0.33	0.48
PHR 8	0.40	0.54
PHR 9	0.49	0.57
PHR 10	0.56	0.56
PHR 11	0.68	0.76
TEXAS	0.52	0.60

Race/Ethnicity & Age - 2002*

Race/ Ethnicity	all ages	% of recipients
White	723,285	24%
Black	533,579	18%
Hispanic	1,465,561	50%
Other	230,144	8%
Total	2,952,569	100%

Age	#	% of recipients
<1	195,738	7%
1-5	697,442	24%
6-14	697,132	24%
15-20	295,640	10%
21+	1,066,304	36%
Total	2,952,256	100%

*CMS MSIS 2002, All Texas Medicaid Recipients.

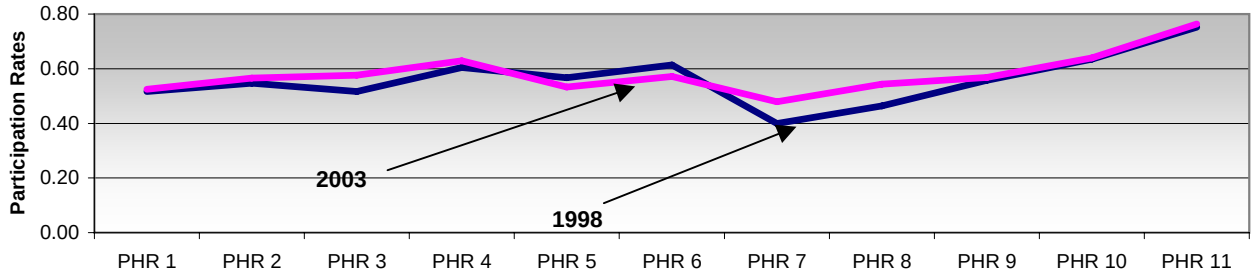
Children aged 1 to 14 in the Texas Health Steps (EPSDT Medicaid) program in 1998 were expected to have 11 checkups during that 14-year period. The number of children with checkups as a percentage of the number of children expected to have a checkup is the participation ratio.

In 2003, the number of recommended checkups for children aged 1 to 14 had increased to 14, and the number of children aged 1-14 receiving checkups had increased 58%.

The different screening schedules compromise comparisons between 1998 and 2003. However, even with the increase in recommended screens and a 30% increase in the number of eligibles, participation for Texas children aged 1 to 14 improved 16%, from 52% in 1998 to 60% in 2003.

In the U.S. summary for 1998, the latest available EPSDT national summary, the participation rate for children 1-14 was 63%.

Participation Rates for Children 1-14



The graph above shows the participation rates by region for 1998 and 2003. Participation in every region increased, except for PHR 6., which decreased slightly and PHR 10, which remained stable over the five year period. In both years, the region with the lowest participation rate was PHR 7 and the region with the highest participation rate was PHR 11. In 2003, PHR 11 had a participation rate of 76%.

Sources: NHIC, HMPR 980K 1998; TMHP, HISR303A and ICHP ad hoc 2003; CMS MSIS 2002; US HCFA-416 1998.

C S H C N

Disability - School Year 1999 - 2000

Disability	# Students	%
Orthopedic Impairment	5,127	1.1%
Other Health Impairment	33,722	7.5%
Hearing Impairment	4,924	1.1%
Visual Impairment	2,147	0.5%
Deaf and Blind	64	0.0%
Mental Retardation	24,370	5.4%
Emotional Disturbance	34,860	7.7%
Learning Disability	261,336	57.7%
Speech Impairment	70,083	15.5%
Autism	4,801	1.1%
Traumatic Brain Injury (TBI)	810	0.2%
Muscular Distrophy (MD)	10,353	2.3%
Total	***452,597***	***100.0%***

Race/Ethnicity - SY99-00

Race / Ethnicity	#	%
White	202,311	44.7%
Black	81,015	17.9%
Hispanic	163,840	36.2%
Other	5,431	1.2%
Total	452,597	

To be eligible to received special education services, a student must have been determined to have one or more of the disabilities listed in either 34 CFR 300.7 or Texas Education Code (TEC) 29.003.

Instructional Setting - School Year 1999-2000

Instructional Setting	Number	Percent
Regular Classroom	127,587	28.2%
Resource Room	236,295	52.2%
Separate Facility	81,287	18.0%
Public- Separate	2,717	0.6%
Private - Separate	100	0.0%
Public - Residence	189	0.0%
Private Residence	23	0.0%
Home	4,399	1.0%
	452,597	***100%***

Children with disabilites receive services in a continuum of alternative placements. The majority of students were served in a resource room in 1999 -2000.

During School Year 1999 - 2000, there were 452,597 students receiving special education services in the State of Texas. The majority of the students were receiving services because of a learning disability (57.7%), while 15.5% of students received services because of a speech impairment, and 7.7% because of an emotional disturbance. The race/ethnic makeup of students receiving special education services was very similar to that of the school age, general population.

Source: Texas Education Agency, Texas Self-Report: Continuous Improvement Monitoring Process, December 2000, School Year 1999-2000

Prevalence of Selected Birth Defects, Texas, 1999-2001: Totals and by Race/Ethnicity

Defect	Cases	Total Rate	White	African American	Hispanic
Central Nervous System					
Anencephaly	319	2.96	2.39	2.05	3.75
Spina bifida without anencephaly	405	3.76	3.39	3.45	4.24
Encephalocele	103	0.96	0.78	0.49	1.19
Microcephaly	726	6.74	5.54	9.36	7.18
Holoprosencephaly	120	1.11	0.81	1.07	1.37
Hydrocephaly	791	7.34	6.99	10.10	7.22
Cardiac and Circulatory					
Transposition of the great vessels	531	4.93	5.57	3.37	4.84
Tetralogy of Fallot	338	3.14	3.10	3.53	3.07
Ventricular septal defect	4,619	42.86	39.48	29.72	50.39
Atrial septal defect	4,226	39.22	39.00	37.03	41.11
Hypoplastic left heart syndrome	213	1.98	2.37	1.97	1.74
Patent ductus arteriosus	4,593	42.62	39.97	39.00	46.88
Respiratory					
Agenesis, aplasia, or hypoplasia of the lung	495	4.59	3.74	4.27	5.51
Oral Clefts					
Cleft palate alone (without cleft lip)	663	6.15	7.34	4.60	5.65
Cleft lip with or without cleft palate	1,172	10.88	10.92	7.55	11.72
Gastrointestinal					
Tracheoesophageal fistula / esophageal atresia	222	2.06	2.44	1.31	2.00
Pyloric stenosis	2,094	19.43	21.67	8.79	21.33
Stenosis or atresia of large intestine, rectum, or anal canal	542	5.03	4.59	4.68	5.59
Genitourinary					
Hypospadias or epispadias	3,111	28.87	40.97	34.65	17.82
Renal agenesis or dysgenesis	557	5.17	4.95	5.09	5.49
Obstructive genitourinary defect	2,210	20.51	22.40	17.82	20.18
Musculoskeletal					
Reduction defects of the upper limbs	446	4.14	3.84	4.19	4.42
Reduction defects of the lower limbs	216	2.00	1.66	2.55	2.18
Diaphragmatic hernia	291	2.70	2.63	2.30	2.85
Omphalocele	244	2.26	2.27	2.63	2.14
Gastroschisis	434	4.03	3.65	2.38	4.88
Chromosomal					
Trisomy 21 (Down syndrome)	1,387	12.87	12.88	7.55	14.29
Trisomy 13 (Patau syndrome)	133	1.23	1.18	1.40	1.15
Trisomy 18 (Edwards syndrome)	239	2.22	2.27	2.30	1.94
Other					
Fetal alcohol syndrome	24	0.22	0.26	0.57	0.12
Infants and fetuses with any monitored birth defect	37,728	350.12	374.16	339.69	340.34

† *cases per 10,000 live births*

Source: DSHS, Texas Birth Defects Registry, Report of Defects Among 1999-2001 Deliveries.

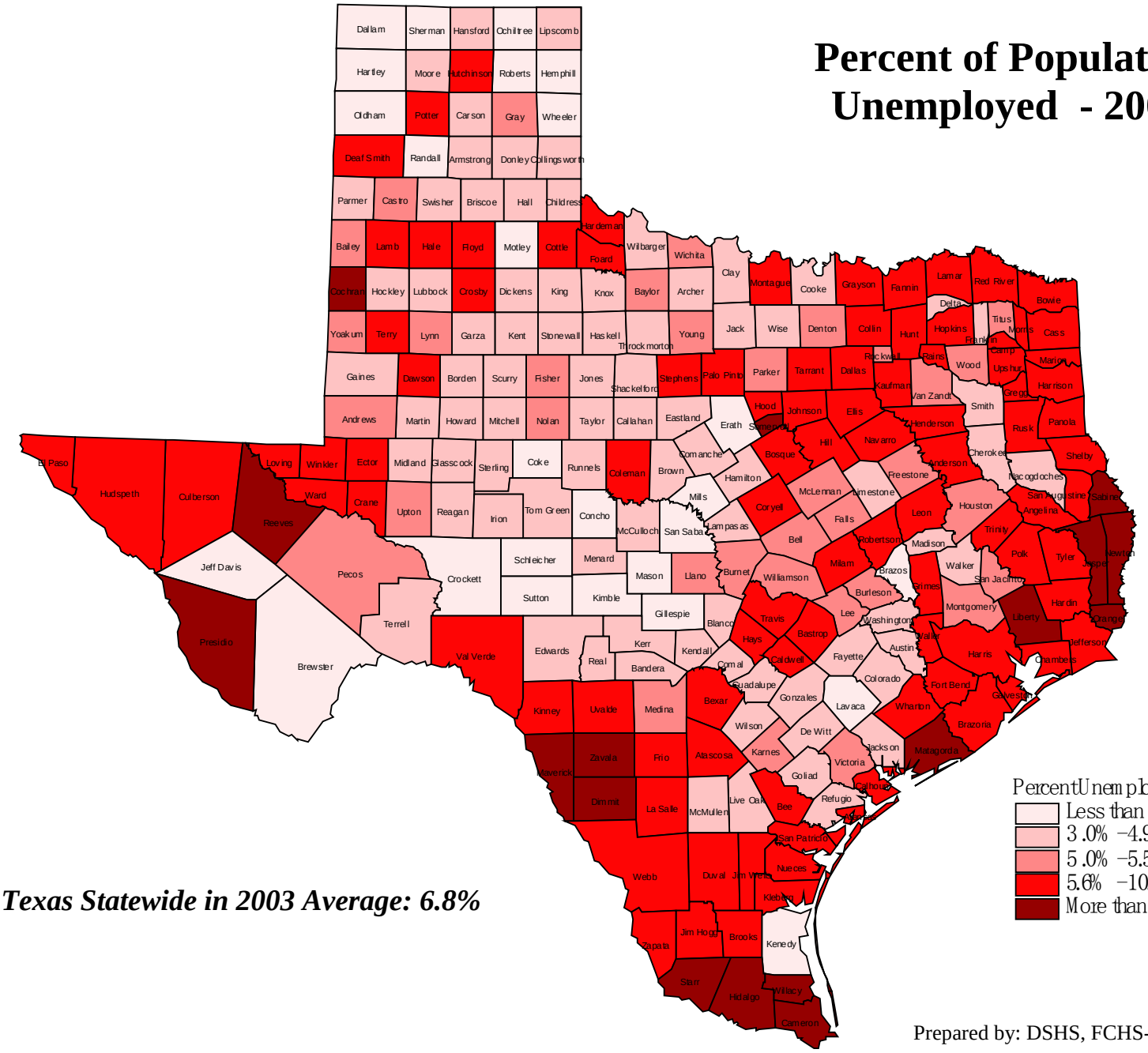
Note:: The Texas Birth Defects Registry now includes statewide reports of birth defects, instead of only regions 6 and 11, as in 1995, the first year of the registry. Rates are calculated on three years of data. Confidence interval calculations are available in the full report, and rates should be interpreted in context of confidence interval information.

More than 13,000 Texas babies are born each year with one or more major structural malformations. Birth defects were the cause of nearly 1/4 of infant deaths in 2002. Certain birth defects have higher rates for some racial/ethnic groups: Hispanic women are significantly more likely to have a baby with anencephaly and African American mothers are more likely to be affected by a digestive tract defect called biliary atresia than women of other ethnic groups. Two-thirds of birth defects are caused by unknown factors.

Needs Assessment

Attachment A-1

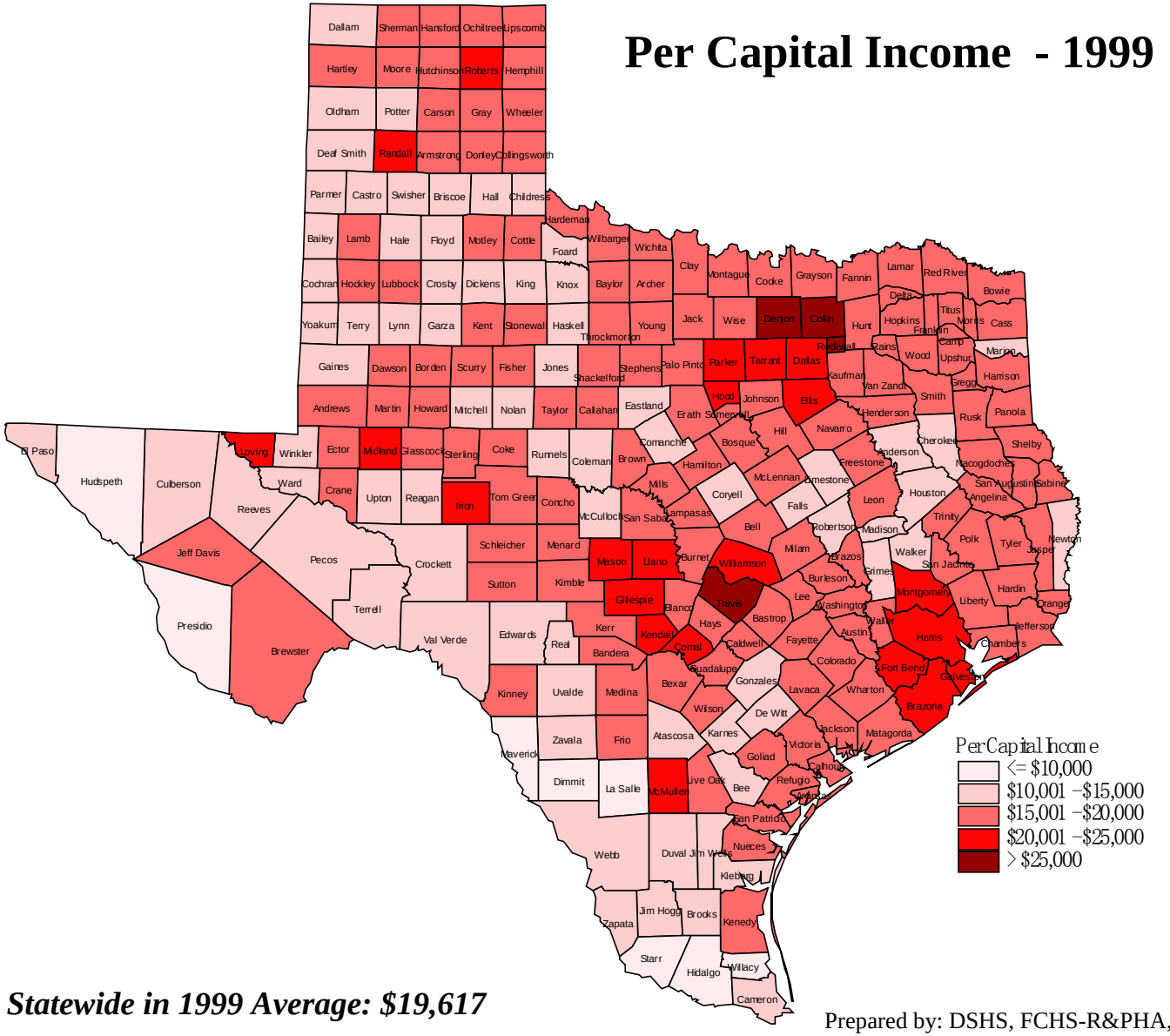
Percent of Population Unemployed - 2003



Texas Statewide in 2003 Average: 6.8%

Prepared by: DSHS, FCHS-R&PHA,12/ 2004

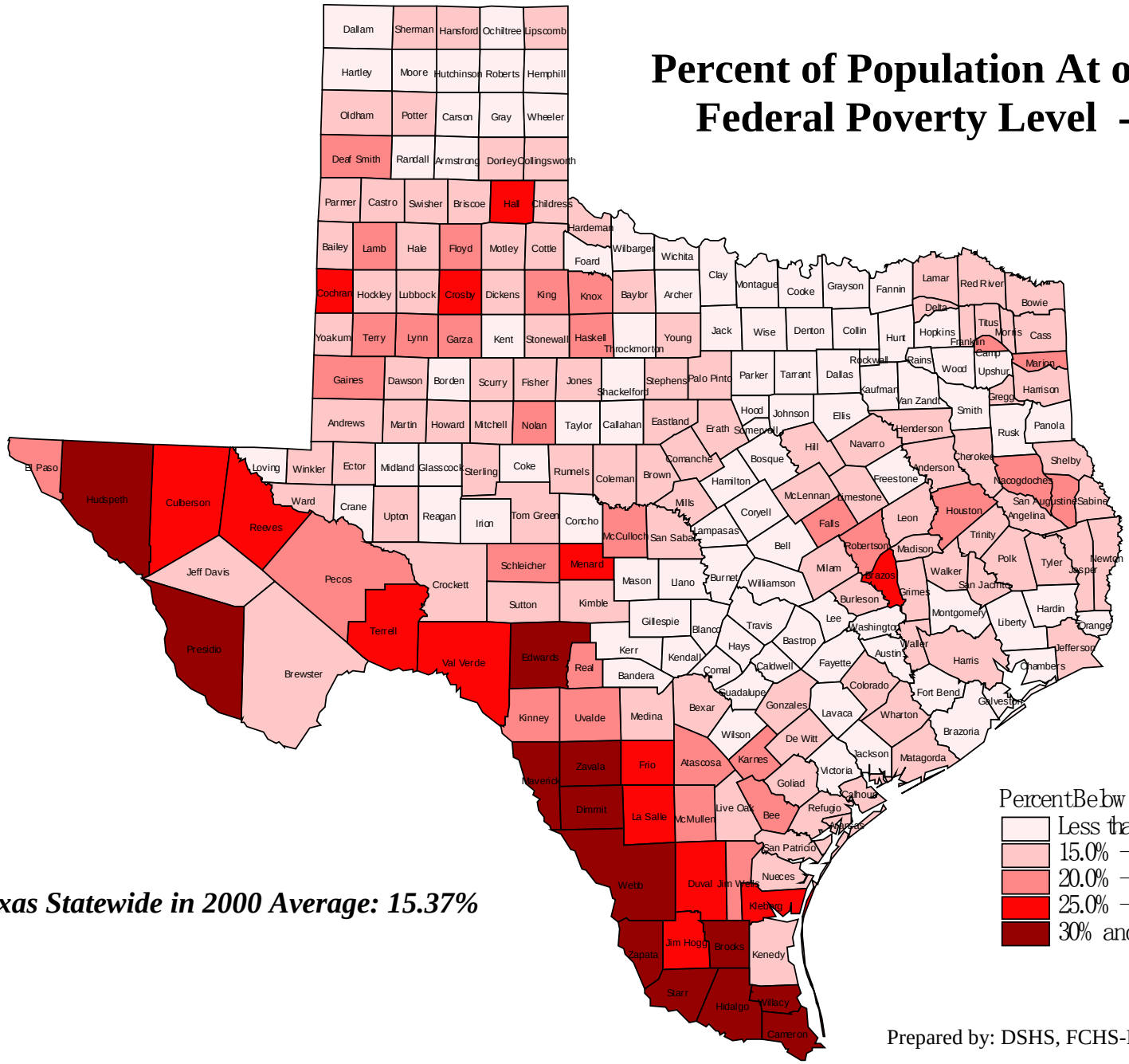
Per Capital Income - 1999



Texas Statewide in 1999 Average: $19,617

Prepared by: DSHS, FCHS-R&PHA, 12/ 2004

Percent of Population At or Below Federal Poverty Level - 2000

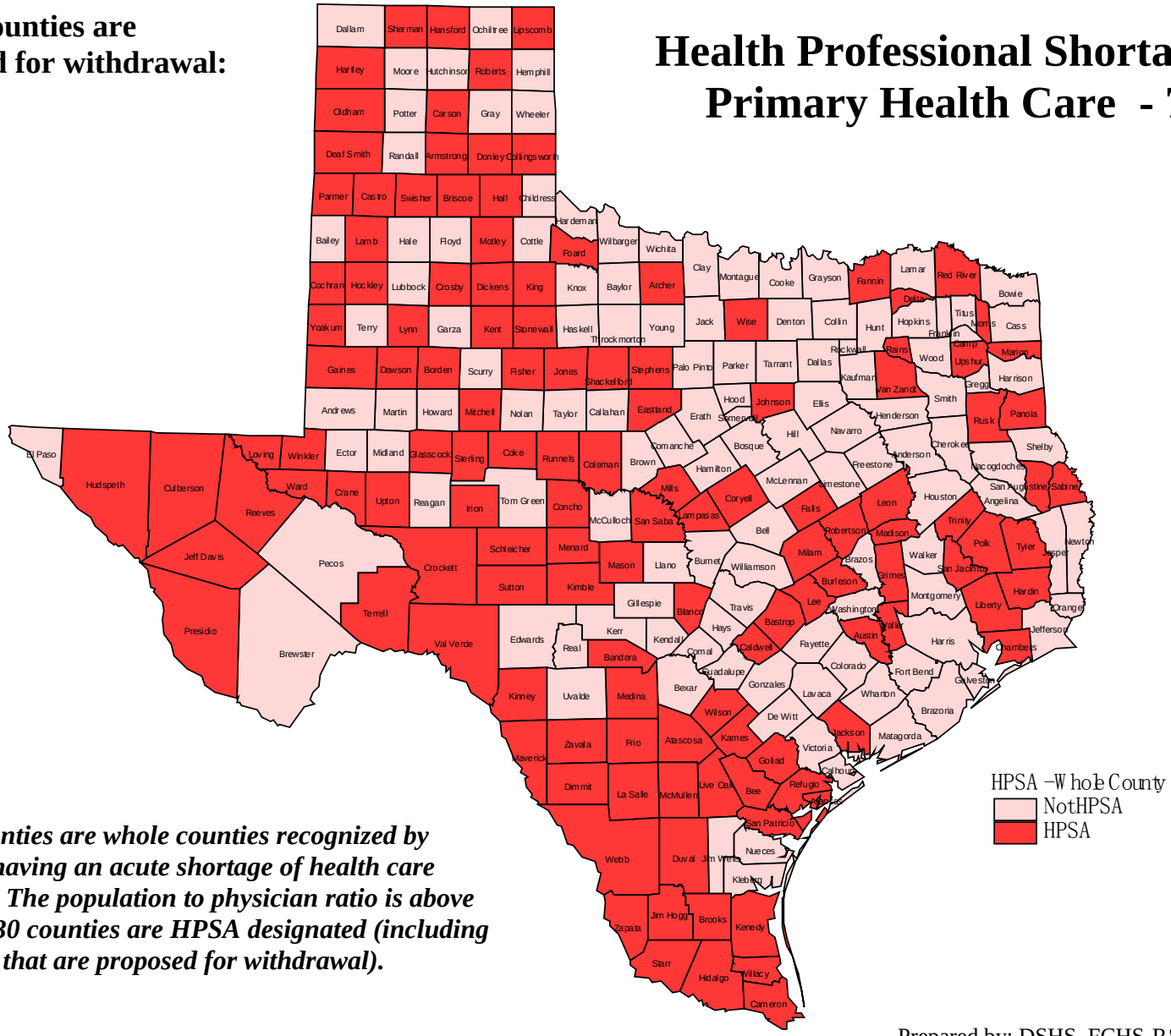


Texas Statewide in 2000 Average: 15.37%

Prepared by: DSHS, FCHS-R&PHA, 12/ 2004

HPSA counties are proposed for withdrawal:
Cameron
Grimes
Hockley
Lampasas
Maverick
Val Verde
Webb
Wise
Willacy

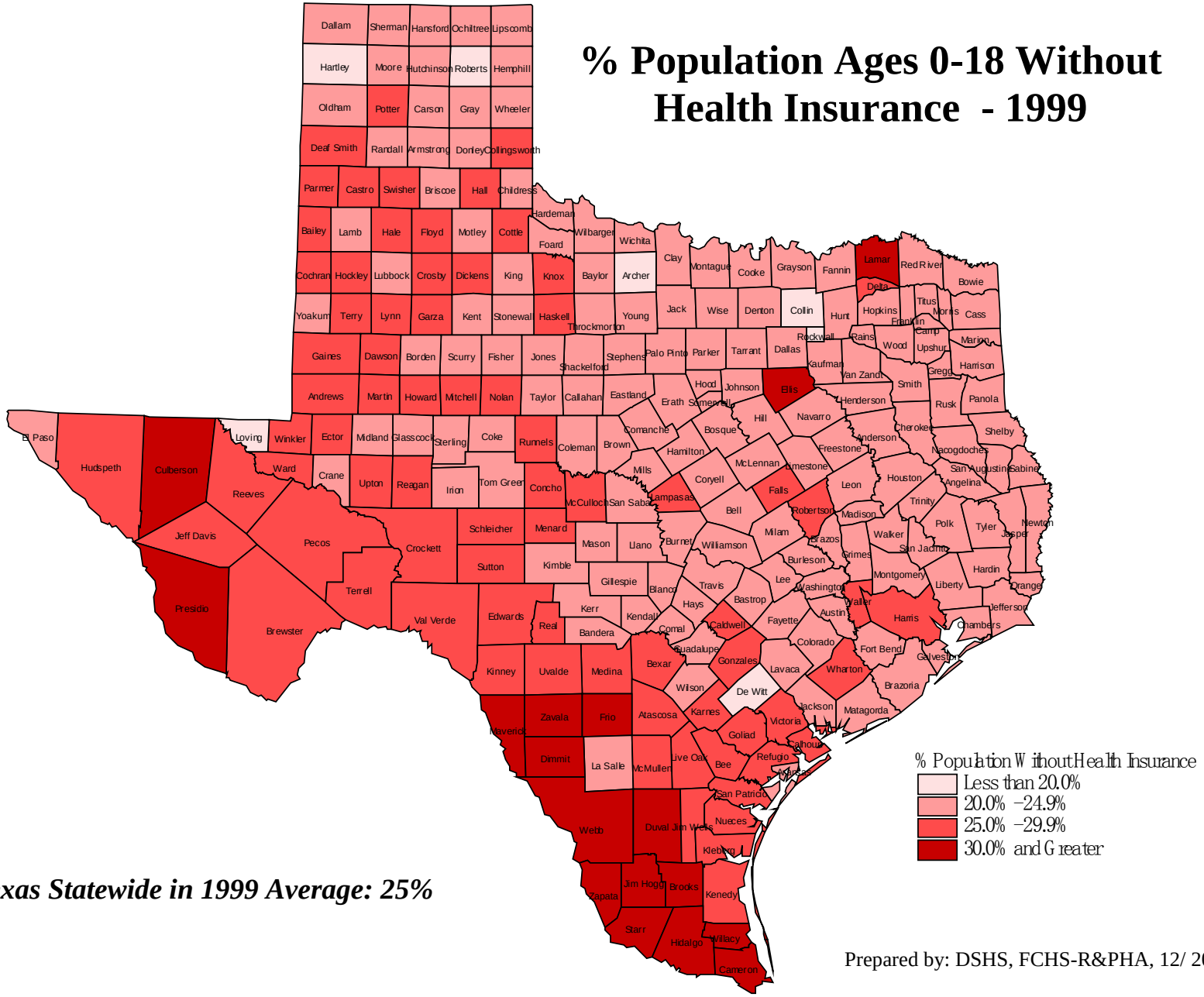
Health Professional Shortage Areas
Primary Health Care - 7/2004



HPSA counties are whole counties recognized by DHSS as having an acute shortage of health care personnel. The population to physician ratio is above 3,500:1. 130 counties are HPSA designated (including 9 counties that are proposed for withdrawal).

Prepared by: DSHS, FCHS-R&PHA, 12/ 2004

% Population Ages 0-18 Without Health Insurance - 1999



Texas Statewide in 1999 Average: 25%

Prepared by: DSHS, FCHS-R&PHA, 12/ 2004

Needs Assessment

Attachment B

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

EDUARDO J. SANCHEZ, M.D., M.P.H.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us

November 1, 2004

Dear Maternal and Child Health Stakeholder:

The Texas Department of State Health Services (DSHS) Title V Program is seeking your input in identifying maternal and child health priority needs to improve the health of Texas' mothers, pregnant women, women of childbearing age, infants, children, and adolescents. Your participation in this needs assessment activity is crucial in developing the five-year mid-range Title V plan and realigning Title V resources and funding to current local and state priority needs for the Title V population-in-need.

In state fiscal year 2003, over 600,000 women, infants, children, and adolescents received Title V-funded services. Texas' Title V Program is part of a federal-state partnership to improve the health outcomes of the Title V population through the delivery of fee-for-service direct health services and enabling services, and the development of the infrastructure building activities locally and statewide. This five-year needs assessment is one of many requirements associated with applying for Title V federal funds. Its results form part of the Texas Maternal and Child Health (MCH) Block Grant Application, due July 15, 2005.

Attachments A and B request your input. Please share your opinions, ideas, concerns, and perceived areas for improvement as you see fit. This input will help to formulate up to ten state performance measures. In addition, Attachment C provides an opportunity for you to suggest major activities associated with Texas' efforts in addressing the 18 national Title V performance measures. As you complete the attachments, consider needs and improvement areas related to the health status of individuals (e.g., obesity, immunization, premature births, low birth weight) as well as health systems development that supports access to and delivery of care (e.g, health insurance, medically underserved areas, surveillance). Please submit your input to TitleVInput@dshs.state.tx.us no later than **November 12, 2004.**

As a critical part of the Title V five-year needs assessment process, the Children with Special Health Care Needs (CSCHN) Program will contact some of you in the near future for additional assistance in prioritizing key issues and recommendations for CSHCN and their families.

The next step in this planning process is the development of a final list of priority focus areas and the activities to support those priorities. Your feedback is important and we will solicit additional stakeholder input at critical stages in this process.

If you have questions, or need additional information, please call me at 512-458-7321 or email your question to TitleVInput@dshs.state.tx.us. Thank you for your input and your ongoing efforts in helping to improve the health of Texas' women, infants, children, and adolescents. We look forward to hearing from you.

Sincerely,

Fouad Berrahou, Ph.D.
State Title V Director
Title V and Health Resources Development Office

Stakeholder Information & Instructions

Thank you for submitting your opinions on the health status and health systems needs, concerns and areas for improvement for Texas' women, infants, children, and adolescents. Please follow these instructions as you complete this form and the following pages:

Part I – Stakeholder Information

Please fill-in information requested. Responses can also be submitted anonymously.

Part I : Stakeholder Information (Completing this information will help us learn more about who responded to our request for input and help us keep you informed of our process.)

Tell us a little bit about you:	
Your name:	
E-mail Address:	
Mailing Address:	
City:	
State:	
Zip Code:	
Public Health Region:	
County:	

Please tell us a bit about your organization:	
Name of organization:	
Type of organization: (check primary organization type)	
☐ Local or City Health Department	☐ Educational Institution
☐ State Health Department	☐ Community-Based Organization
☐ Business or Commercial	☐ Hospital or Health Care
☐ Federal Agency	☐ Professional Organization
☐ Advocacy Group	☐ None, representing self
☐ Other, specify:	

Part II a & b: Stakeholder Feedback (see Attachments A & B)

- Please fill-in information requested.
- Fill-in one sheet for the population you want to provide feedback on, you do **NOT** need to complete more than one sheet but may if you like!
- Complete one Topic Area for each need, concern or improvement area.
- Be brief, but specific – answer who, what, when, where and how in your brief statements.
- Use **ONLY** the space provided.

Part III –National Performance Measures Feedback (see Attachment C):

- Suggest major activities that could be implemented at the local or state level to address one or more of the national performance measures.
- If you would like the state to consider implementation of a best-practice activity – please note where the Texas Title V Office may find more information about the specific best practice noted.
- Use **ONLY** the space provided.

Submit your feedback no later than November 12, 2004	
Email: TitleVInput@dshs.state.tx.us	**Regular Mail:** Title V Input Texas Title V Program Office Dept. of State Health Services 1100 W. 49th Street Austin, Texas 78756

Respond no later than November 12, 2004 – Thank you!

Instructions: Review sheet labeled **"INSTRUCTIONS"** prior to completing the forms!

WOMEN & INFANTS
(over 22 years) & (0-11 months)

Part II a - Title V Needs Assessment **Provide feedback on at most 3 TOPIC AREAS for the WOMEN & INFANT population groups**

Use **ONLY** the space provided

TOPIC AREA 1

Briefly state the need, concern, or area for improvement.
(for example: Decrease the incidence of pertussis disease in our community for infants.)

What is your rationale for stating this need, concern, or area for improvement?
(for example: Disease data from FY 02 indicates there were 70 infant cases of pertussis disease and 4 deaths related to the disease.)

List up to two activities that could be undertaken in your community or at the state level to address this need, concern, or area for improvement.
* (for example: State to develop multi-media parent based messages concerning the dangers of pertussis disease and the need for age appropriate immunization.)

Activity 1:

Activity 2:

TOPIC AREA 2

Briefly state the need, concern, or area for improvement.

What is your rationale for stating this need, concern, or area for improvement?

List up to two activities that could be undertaken in your community or at the state level to address this need, concern, or area for improvement.

Activity 1:

Activity 2:

TOPIC AREA 3

Briefly state the need, concern, or area for improvement.

What is your rationale for stating this need, concern, or area for improvement?

List up to two activities that could be undertaken in your community or at the state level to address this need, concern, or area for improvement.

Activity 1:

Activity 2:

Respond no later than November 12, 2004 – Thank you!

Instructions: Review sheet labeled **"INSTRUCTIONS"** prior to completing the forms!

Children & Adolescents
(age 1 through 21 years)

Part II b - Title V Needs Assessment **Provide feedback on at most 3 TOPIC AREAS for the CHILDREN & ADOLECSENTS population groups**

Use **ONLY** the space provided

TOPIC AREA 1

Briefly state the need, concern, or area for improvement.
(for example: Decrease the incidence of suicide on college campuses in Texas.)

Specify a targeted age group, if appropriate:
☐ 0-3 ☐ 0-6 ☐ 6-12 ☐ 13-17 ☐ 17-21 ☐ All (0-21)

What is your rationale for stating this need, concern, or area for improvement?
(for example: Statewide data indicates that 50 students committed suicide on Texas' college campuses in FY 02)

List up to two activities that could be undertaken in your community or at the state level to address this need, concern, or area for improvement.
* (for example: Develop and deliver training to 50% of all Texas public universities student health centers on suicide prevention.)

Activity 1:

Activity 2:

TOPIC AREA 2

Briefly state the need, concern, or area for improvement.

Specify a targeted age group, if appropriate:
☐ 0-3 ☐ 0-6 ☐ 6-12 ☐ 13-17 ☐ 17-21 ☐ All (0-21)

What is your rationale for stating this need, concern, or area for improvement?

List up to two activities that could be undertaken in your community or at the state level to address this need, concern, or area for improvement.

Activity 1:

Activity 2:

TOPIC AREA 3

Briefly state the need, concern, or area for improvement.

Specify a targeted age group, if appropriate:
☐ 0-3 ☐ 0-6 ☐ 6-12 ☐ 13-17 ☐ 17-21 ☐ All (0-21)

What is your rationale for stating this need, concern, or area for improvement?

List up to two activities that could be undertaken in your community or at the state level to address this need, concern, or area for improvement.

Activity 1:

Activity 2:

Respond no later than November 12, 2004 – Thank you!

Instructions: Review sheet labeled **"INSTRUCTIONS"** prior to completing the forms!

Title V National Performance Measure	Healthy People 2010 Goal	FY 03 Performance	Stakeholder Input Suggested Major Activities *(Use ONLY the space provided)*
Percent of **newborns screen** and confirmed with conditions mandated by their state-sponsored NBSP who received appropriate follow-up as defined by their state	95%	95.6%	
Percent of **CSHCN** (0-18 yrs) whose families partner in decision making at all levels and are satisfied with services they receive	NA*	57.1%	
Percent of **CSHCN** age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home	NA	58.4%	
Percent of **CSHCN** age 0-18 whose families have adequate private or public insurance to pay for the services they need	NA	52.9%	
Percent of **CSHCN** age 0-18 whose families report the community-based systems are organized so they can use them easily	NA	76.9%	
Percentage of youth with **CSHCN** who received the services necessary to make transition to all aspects of adult life	NA	5.8%	
Percent of 19-35 months olds who have received full schedule of age appropriate **immunizations** against: MMR, Polio, Diphtheria, Tetanus, Pertussis, HIB and Hep B.	90%	68.7%	
Rate of **birth** (per 1,000) for **teenagers** aged 15 through 17 years	50.0	40.6	
Percent of 3rd grade **children** who have received protective **sealants** on at least one permanent molar tooth	50%	43.4%	
Rate of **deaths** to **children** aged 14 yrs and younger caused by motor vehicle crashes per 100,000 children	3.5	5.6	
Percentage of mothers who **breastfeed** their **infants** at hospital discharge	80%	70%	
Percentage of **newborns** who have been screened for **hearing** before hospital discharge	NA	82.4%	
Percent of **children** without health insurance	NA	22.7%	
Percent of potentially Medicaid-eligible **children** who have received a service paid by the **Medicaid** Program	NA	60%	
The percent of very **low birth weight infants** among all live births	1.0%	1.3%	
The rate (per 100,000) of **suicide** deaths among **youths** aged 15 through 19	8.2%	8.2%	
Percent of very **low birth weight infants** delivered at facilities for high-risk deliveries and neonates	90%	52.9%	
Percent of infants born to pregnant **women** receiving **prenatal care** beginning in the first trimester	90%	80.8%	

Respond no later than November 12, 2004 – Thank you!

***NA** – Information not available

Needs Assessment

Attachment C

Stakeholder Input (Women & Infants)		
Direct Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Direct Services
Increase awareness of the benefits of breastfeeding. Awareness needs to start with state employees first.	Have Clinicians address breastfeeding when treating their patients	
Increase awareness of postpartum depression in order to help women deal more effectively with this illness.	Have Clinicians address this issue (PPD) with women who are pregnant or plan to be pregnant	
Decrease the incidence of birth defects in Texas	Provide free or low-cost vitamins containing the recommended amount of folic acid to low-income women of childbearing age in Texas.	
Reduction of domestic abuse and violence.	State to publicize and provide in-hospital Emergency Contraception pills	
Enabling Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	General
Increase access to prenatal and postpartum care for undocumented women.	Promote programs to educate undocumented women about their rights.	
Increase access to prenatal and postpartum care for undocumented women.	Encourage the funding of centers and/or coalitions that will help by offering referrals, translation services, help with transportation, etc	
Increase access to prenatal care in first trimester for maternity patients.	Better preconception counseling and education at family planning visits.	Preconception and Interconception
Need for bilingual classes in the area of childbirth preparation, newborn care, postpartum care, and family planning methods.	Availability of (bilingual) educational classes with modules that include childbirth preparation, newborn care, postpartum care, and family planning methods for prenatal patients.	Translation
Decrease the incidence of late or no prenatal care among women residing in counties served by PHR 6/5 South clinics.	Investigate the feasibility of DSHS providing vouchers for transportation to high-risk specialty care at out of county medical sites.	Transportation
Undocumented clients have program access, but may not be able to access services that are outside of their hometown. This correlates with topic area 1 in that there are not services available locally.	Assist with transportation services for these clients with non-emergency needs	
Increase prenatal care for young mothers.	Increase publicity about Medicaid transportation	
Child care for mothers attending schools.	A program in local schools to provide childcare for students	Child Care

Stakeholder Input (Women & Infants)		
Population-based Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	General
Decrease health disparities among minority women.	Reduce demand by educating and providing women with reliable and easy to use tools such as the Healthwise Self-Care manual, available in English and Spanish, which addresses over 200 common health problems	
Increase accessibility of services for undocumented families, especially adults.	Provide written information to put into the hands of parents	
Increase number of pregnant women receiving prenatal care beginning in the first trimester.	Consumer education regarding the availability of services for non-insured pregnant women	
Decrease infant mortality rate in Texas	Expand public awareness of and actively promote the benefits of midwifery maternity services for women having normal pregnancies.	Access
100% of prenatal clients deliver using emergency Medicaid with intent to have infants followed privately but fail to F/U with eligibility papers thusly leaving the infants without any payment source; 2 weeks blood test &well child ed, interventions.	Reinstate funded client education classes during PNC to address issues and prepare mom independence using resources, rapport with professionals while providing group dynamics and community	
Increase the access to prenatal health and childbirth education for Spanish-speaking, immigrant women.	State can develop public health messages targeting the Hispanic immigrant population to raise awareness about key prenatal health concerns	
Increase accessibility of services for undocumented families, especially adults.	Put information on the web that could be downloaded by community service workers	Community Outreach
Increase the trimester of entry for prenatal patients.	Expand community outreach programs	
Increase the percentage of pregnant women accessing prenatal care in their first trimester.	Increase awareness of the importance and availability of prenatal care by hiring community outreach aides or promotoras to reach the population at risk	
Add literacy education for infants and young children beginning at 6 months of age.	• Add literacy program such as 'reach out and read' to Medicaid and CHIP. • Multimedia campaign on early childhood literacy.	Literacy
Increase breastfeeding in the early postpartum period to 75%.	Develop bilingual PSAs promoting the importance of breastfeeding and the availability of programs	Breastfeeding

Stakeholder Input (women & Infants)		
Population- based Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Breastfeeding Cont.
More women need to breastfeed for the health of their infants, and themselves, if not for financial reasons. We need to continue to work on changing this to make breastfeeding the societal norm. This would help the obesity problem, also.	• Breastfeeding Media Campaign at the State Level. Social Marketing to determine the best way to increase breastfeeding rates, especially in the most vulnerable (at risk) populations • Social Marketing to determine the best way to increase breastfeeding rates, especially in the most vulnerable (at risk) populations	
Increase awareness of the benefits of breastfeeding. Awareness needs to start with state employees first.	Promote awareness about the benefits of breastfeeding through the media	
Breastfeeding	Support lactation support services through media activities	
Increase the number of low birth weight (< 3 pounds) infants and premature (<32 weeks of gestational age) infants receiving breast milk while in neonatal units and at time of hospital discharge.	Educate the public about the superiority of mother's milk over formula for babies less than one year of age and particularly for ill and premature.	
Increase the rate of breastfeeding among low-income infants.	Provide breast pumps to all breastfeeding moms in WIC	
Increase rates of breastfeeding by 90% of the first three months of life.	Assist local hospital in attaining 'Baby Friendly' status	
Improve breastfeeding initiative and duration for healthier babies and mothers.	Promote breastfeeding to all pregnant women	

Stakeholder Input (women & Infants)		
Population- based Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Breastfeeding Cont.
Improve breastfeeding initiative and duration for healthier babies and mothers.	Support breastfeeding moms and provide lactation assistance for moms who are having breastfeeding difficulties especially during the early postpartum period. Employ more IBCLCs in hospitals and provide in-home support for breastfeeding moms	
Decrease low birth weight births by improving the health status of women i.e. decreasing social isolation and increasing inter pregnancy intervals.	Market family planning services to decrease short inter-pregnancy intervals	Preconception and Interconception
Increase the proportion of pregnancies begun with an optimum folic acid level.)	Conduct education campaigns to childbearing age women, especially to high school girls and college women.	
Increase prenatal care during the first trimester for all women.	Partner with the March of Dimes to deliver culturally appropriate PSAs	PNC
Decrease the percentage of women receiving late or no prenatal care.	State to develop multi-media messages directed to minority and low-income WCBA concerning the importance of early prenatal care	
Increase access to prenatal care in first trimester for maternity patients.	Community outreach at WIC or day cares to help mothers realize importance of early prenatal care.	
Low Birth weight- Decrease the number of low birth weight infants being born.	Educate parents on the importance of prenatal care	
Increase number of pregnant women receiving prenatal care beginning in the first trimester.	Consumer education regarding the importance of early prenatal care	
PNC	Develop multimedia messages that inform people about the benefits of PNC	
Increase prenatal care in first trimester.	Education	
Reduce the incidence of premature births in Texas	Educate pregnant women on the signs and symptoms of preterm labor and the appropriate action to take if symptoms present.	Prematurity
Reduce the incidence of premature birth in Health Service Region 4/5 North.)	-Promote appropriate educational programs and materials designed for childbearing women on how to reduce risk of premature birth and how to recognize signs of premature labor as well as what to do in an emergency	

Stakeholder Input (Women & Infants)		
Population-based Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Low Birth Weight
Decrease the incidence of low birth weight in infants born to women in Aransas, Bee, and Jim Wells Counties.	Increase awareness to populations at risk of the consequences of low birth weight infants and the probability of infants with development delays	
Decrease the incidence of low birth weight infants < 2500 Grams or 5 lbs. 9 ozs. in Health Region 7.	Target prenatal care providers in Region 7 in those counties with high incident of low birth weight infants to encourage patient education efforts and appropriate referrals for high-risk behaviors in order to take steps to reduce low birth weights	
Decrease the incidence of low birth weight in infants born to women in Aransas, Bee, and Jim Wells Counties.	Media campaign to women of childbearing age on the importance of early prenatal care, healthy eating habits, and healthy lifestyles. The campaign should include the dangers of smoking, using drugs and drinking alcohol during pregnancy	
Decrease the infant mortality rate in the State of Texas	State to increase community awareness of infant mortality through multi-media messages	Infant Mortality
Nutritional counseling	Disperse freely videos, publications and other materials for patient education	Nutrition
Young children and adult high incidence of unhealthy eating habits and obesity.	Start this education (healthy nutritional programs) via TV, radio, health fairs, MD offices, etc., Social Services	
Poor nutrition in prenatal patients.	Expansion of WIC services, outreach into communities (churches etc.) to inform patients about the importance of good nutrition.	Nutrition/Physical Activity
Decrease low birth weight births by improving the health status of women i.e. decreasing social isolation and increasing inter pregnancy intervals.	Implement a physical activity campaign that increases social interaction (walking groups/buddy programs), combined with a media campaign that specifically focuses on increasing women's physical activity	
Nutrition, preventing obesity	• Nutrition education about infant feeding. • Family physical activity	
Extensive healthy eating habits throughout a child's educational primary and secondary schooling.	Media campaigns delivered on importance of good dietary habits starting at an early age	
95% prenatal clients Hispanic with children developing obesity that is considered good in culture; provide in-home group support and community resources.	Community gardens can be located in areas identified as locales for the PN clients to promote planting/harvesting and ways of cooking to decrease fat used in diet and alternatives for cooking methods.	
Decrease the incidence of obesity among adults	Develop a statewide campaign to promote regular physical activity and calorie balance as weight control.	
OBESITY---This is a growing epidemic in our State.	Parental education of mothers regarding nutrition for their infants/children is our best chance to stem this epidemic. Dr. Steve Ponder of Corpus Christi has a plan to attack obesity, contact him or TMA Committee on Children &Adolescence or Texas Pediatric Society's Pediatric Practice Committee or School or Dr. Barnet on School based initiatives (apply to daycare)	

Stakeholder Input (Women & Infants)		
Population- based Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Nutrition/Physical Activity cont.
95% prenatal clients Hispanic with children developing obesity that is considered good in culture; provide in-home group support and community resources.	Engage Ag. Extension in planning and teaching to clients alternative for cooking, growing, selection, choices when grocery shopping, neighborhood support groups for cooking	
Increase substance abuse services for women and infants	Local coalitions with state health services develop PSA's for substance abuse prevention and intervention availability.	Substance Abuse
Decrease the number of women of childbearing years abusing drugs and alcohol.	Increase education to the community regarding the effects of alcohol, tobacco and other drugs, including the effects on human growth and development and fetal development	
Educate females, moms on FASD	• Provide education to high schools on Fetal Alcohol Spectrum Disorder (FASD) • Provide educational materials to pregnant females on the harm alcohol does to a fetus	
Increase awareness of postpartum depression in order to help women deal more effectively with this illness.	Increase awareness of postpartum depression via the media, educational presentations by the state, require clinicians to address this issue	Postpartum Depression
Large numbers of new parents lack of basic parenting and child development skills and lack information or knowledge of how to access information that can benefit their child's health and development.	Reinstate Take Time for Kids/Texas Tots/Building Blocks mail outs that provide developmental information to families at timely intervals (age paced so that parents receive issues appropriate to their child's age/developmental needs) - not in bulk	Child Development
Reduce HIV rates in minority females.	Curriculum for grandparents to teach them how to talk to grandchildren about risk avoidance for HIV.	HIV/STD
Decrease the incidence of Chlamydia	• Educate about sexually transmitted disease prevention • Educate about the importance of testing for sexually active individuals and yearly pap-smears for sexually active women	
Increase rates of breastfeeding by 90% of the first three months of life.	Involve more community-based dentist in teaching importance of good oral health during pregnancy and early infant years	Oral Health
Increase education and awareness about the importance of taking care of children's teeth even before they are born.	Include information concerning the importance of good oral hygiene in prenatal education and parenting classes	

Stakeholder Input (Women & Infants)		
Population- based Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Screening
Breast cancer awareness and detection for women 40-64 years of age and those younger if indicated.	Continued education for the population on the importance of mammogram and early detection of breast cancer	
Reduce infertility in women of childbearing age by reducing chlamydia incidence and through improved chalmydia screening.	Provide online screening tools that are based on CDC screening and treatment guidelines. See http //www.ehdp.com/cgi-bin/stdwzd.cgi as an example of an online STD	
Improve the availability of specialized addiction treatment services for women, particularly those that treat pregnant women and women with infants and young children.	Identify pregnant women who are drinking and using drugs.	
Decrease the number of infants exposed to drugs or alcohol during pregnancy.	Increase identification of the number of women of childbearing years who are currently using substances or are at-risk of substance abuse through improved screening by medical and social service professionals.	
Increase the proportion of preschool children aged 5 years and under that receives vision screening.	Improve screening programs and access to these programs.	
Newborn hearing screening needs to be expanded to all birthing facilities in the state.	Middle ear infection generally begins with Eustachian tube dysfunction, resulting in negative middle ear pressure and finally in middle ear fluid-infection. These signs are first and most reliably detected by Audiological examination	
Decrease incidence of MRSA	Develop education on how to prevent the spread of MRSA, especially community –acquired MRSA	Infectious Disease
Decrease incidence and spread of hepatitis	Develop education how to prevent spread of hepatitis	
Decrease incidence of Shigella	Decrease incidence by prevention and spread through community education	
Increase the immunization level for all vaccine preventable diseases to a level of 90 % [Goal].	Multimedia messages in every area of the state.	Immunization
Increase the immunization level for all vaccine preventable diseases to a level of 90 % [Goal].	Campaign should include immunization clinic. Having that can be most convenient for working families.	
Immunizations--We are still at bottom of States in our goal to immunize. We need to be in the top ten.	Support TMA's Be Wise--Immunize Campaign throughout the State	

Stakeholder Input (Women & Infants)		
Population- based Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Immunization
Increase immunization rates among young children.	Develop and sustain a (immunization) media campaign	
Decrease the incidence of heart disease and stroke among women.	Collaborate with the American Heart Association to promote Go Red For Women media campaign.	Cardiovascular Disease (CVD)
Increase awareness of expectant mothers on requirement of child safety seat before an infant is released from the hospital and proper installation of the child safety seat in the vehicle.	Update Safe Riders brochure to ensure it includes requirement to have a car seat before hospital discharge. Disseminate through providers, childbirth classes, etc.	Injury Prevention
Increase awareness of expectant mothers on requirement of child safety seat before an infant is released from the hospital and proper installation of the child safety seat in the vehicle.	Certify medical personnel who work with newborns in the NHTSA Child Passenger Safety curriculum and have them educate expectant parents during birthing classes. Have them inspect placement of child safety seat in the vehicle prior to discharge.	
Educate all high school students on parenting	Provide educational materials to high schools	
Educate young moms on child safety issues ie car safety, leaving children in car.	• PSAs addressed to young parents and children about safety issues • More car safety seat classes and education at Head Start, Even Start programs and Planned Parenthood	
Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Policy
Lack of after hours services for non-emergency health care for working poor.	Incentives to providers to offer after-hours services	
Increase women and infants access to local healthcare services.	Increased role by local state health departments to evaluate barriers, develop action committee and address barriers individually, to improve service accessibility to those in community	
Increase women and infants access to local healthcare services.	Address issue of medically understaffed providers via additional hiring incentives, development of medical training facilities, grow current state facilities	

Stakeholder Input (Women & Infants)		
Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Policy
Maintain ability of women and infants enrolled in STAR, STAR+PLUS and CHIP HMO plans to obtain care at federally funded hemophilia treatment centers (HTCs).	Require STAR, STAR+PLUS and CHIP HMO plans statewide to include federally-funded HTCs in their provider networks to ensure access to expert hemophilia	
Decrease the incidence of late or no prenatal care among women residing in counties served by PHR 6/5 South clinics	Increase the number of low risk prenatal clients seen in regional public health nursing clinics. 1a) Develop less restrictive policies for determining 'low risk' and eligible for PNC in regional nursing clinics. 1b) Local multimedia to promote PNC	
Increase the level of newborns AND mothers receiving post-birth health care, education and preventative services regardless of their ability to pay.	State Medicaid should undertake to cover BOTH the mother and a newborn child for at least the first 12-24 months from birth	
Low birth weight infants that survive long, costly stays in neonatal intensive care subsequently experience increased rates of emergency department visits, hospitalizations and pediatric ICU status during the first years of life.	Expand specialized, comprehensive primary care follow-up services to include all very low birth with infants and all low birth weight infants meeting risk criteria, such as infants of adolescent mothers	
Change the Texas Standard for second newborn lab screen from 7 to 14 days allowing for it to be completed at 3 to 4 days of life.	Change the Texas Standard for second newborn lab screen from 7 to 14 days allowing for it to be completed at 3 to 4 days of life. Families are less likely to complete two visits within the first week (one for early follow-up and one for a second lab)	
Decrease the incidence of teenage pregnancy.	Introduce reproductive health education in schools.	
Decrease the incidence of low birth weight infants < 2500 Grams or 5 lbs. 9 ozs. in Health Region 7.	Coordinate with Region staff with Preventive Functions to develop strategies to address high-risk behaviors that can result in low birth weight infants in prenatal patients.	
Increase the availability of prenatal services to Title V patients	Advocate with state Title V to recognize problem of gap in prenatal services and to initiate efforts to explore possible solutions.	
Increase the availability of prenatal services to Title V patients.	Identify prenatal providers in counties with prenatal care gaps for Title V clients and open discussions for alternative solutions e.g. sliding scale; strengthen local infrastructure.	

Stakeholder Input (Women & Infants)

Infrastructure Services

Suggested Needs/Activities from Stakeholders		Type of Service
Need	**Activity**	Policy
Increase the percentage of pregnant women accessing prenatal care in their first trimester.	Increase the number of providers by developing incentives e.g. increase the reimbursement rates for prenatal and delivery services.	
Decrease the incidence of obesity among adults.	Promote policies and environmental changes that support healthful eating habits and physical activity.	
Extensive healthy eating habits throughout a child's educational primary and secondary schooling.	Start with revamping entire nutritional information provided at schools	
Increase the level of newborns AND mothers receiving post-birth health care, education and preventative services regardless of their ability to pay.	GCC will increase our proactive outreach to Medicaid and CHIP families with regular interaction and encouragement to continue adhering to preventative health protocols	
More funding for prevention of unplanned pregnancies would do more than any other one activity to decrease mortality and morbidity related to women's health.	Women's Health Medicaid Family Planning waiver	
Increase the rate of breastfeeding among low-income infants.	Provide enhanced food packages to moms who breastfeed (more than is done now.	
Reduce the % of low birth weight (2500 gm) in Hidalgo County	Educate the elected officials (local & state) to the needs of the community in providing/accessing health care to the indigent population	
Increase the percent of pregnant women entering into prenatal care at our clinics during the 1st trimester.	The state must assess the areas of need before granting monies to the agencies applying for Title V monies	
Increase the percent of pregnant women entering into prenatal care at our clinics during the 1st trimester.	This also should include assessing the population growth and the # of undocumented entering into and residing in the community	
The state should evaluate the areas in need, specifically the border counties, for increased funding in order to provide services for those in need (the underinsured).	The state should evaluate the areas in need, specifically the border counties, for increased funding in order to provide services for those in need (the underinsured).	
Dental care	Decrease costs to patients	

Stakeholder Input (Women & Infants)		
Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Policy
Decrease infant mortality rate in Texas.	Support legislation to make midwifery a truly independent and autonomous profession in Texas with its own Governor-appointed, independent regulatory Board	
Expand availability of prenatal, delivery and postnatal care to Texas women.	Support legislation expanding the scope of emergency care that can be provided by midwives - to maintain the safety of home birth in remote rural areas.	
Educate all high school students on parenting	Make parenting a required course for all high school students	
Increase health coverage for infants / pregnant women.	Have coverage available for women postpartum for longer period of time	
Promote awareness of dangers of drug use during pregnancy.	Mandate drug testing on pregnant women	
Promote awareness of dangers of drug use during pregnancy.	Make drug abuse training mandatory at least one prenatal visit	
Comprehensive sex education in rural schools and communities.	School districts able to educate students on sex education and the human body beside watered down lessons during health	
Women's Health particularly in the area of family planning among teens as well as women within childbearing ages	Expansion of Medicaid benefits for family planning and related women's preventive health care beyond 6-weeks postpartum	
A concern related to Topic Area 1which is the need for expansion of Medicaid benefits to women who currently do not qualify.	Effect legislation to change Medicaid requirements to include these uncovered women or seek other funding avenues to address the issue	
Improve breastfeeding initiative and duration for healthier babies and mothers.	Work towards placing restrictions on allowing formula companies to advertise in prenatal and pediatric clinics MCH/Title V agencies operate	
Newborn hearing screening needs to be expanded to all berthing facilities in the state.	Implement universal newborn hearing screening testing at all birthing facilities statewide. Educate mothers to have their children's hearing tested annually through sixth grade. Get an audiological evaluation at first signs of cold or sore throat	
The long standing value of 'Community First' for children with special health care needs and disabilities must survive the newly reorganized DSHS.	Hire and keep leadership in CSHCN who embrace 'Community First' values. Advocate for the CSHCN Advisory Committee function to be restored, at DSHS or as a component of another children's advisory committee. Maintain trust with advocates and within the HHSC system that CSHCN will support and implement the state's policy that children belong in families and continue to actively participate in the Children's Policy Council advisory process	

Stakeholder Input (Women & Infants)		
Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Policy
Increase the rates of long-term breastfeeding (LTBF, at least 6 months) thus improving nutritional habits of child and parents	Forbid the display, promotion and/or distribution of formula and bottles throughout healthcare system, especially ob/gyn and pediatric offices.	
Decrease preterm birth rate	Reduce cost ineffective duplication of services through education on the need for a timelier referral based on patient risk factors.	Professional Training and Materials
Decrease the language, cultural and geographic barriers to care that exist.	Reduce cost ineffective duplication of services through education of patients and providers. Thereby reducing the barriers to care involved in high-risk referrals, by empowering our patients to feel they play a role in their medical decisions	
Decrease the incidence of children born ATOD affected, decrease low birth weight infants; decrease incidence of postpartum depression; prevent domestic violence	• Provide on-site substance abuse, mental health and domestic violence screening for all women. • Cross train staff on domestic violence, substance abuse, mental health and child abuse and neglect	
Increase accessibility of services for undocumented families, especially adults.	Put information on the web that could be downloaded by community service workers	
Lack of after hours services for non-emergency health care for working poor.	Provider education on client demographics and needs	
Increase the rates of long-term breastfeeding (LTBF, at least 6 months) thus improving nutritional habits of child and parents.	Improve education of hospital staff and strengthen/invest in partnerships with community-based breastfeeding support organizations.	
Increase support for breastfeeding mothers.	Disseminate breastfeeding resource list to health care providers. Include in all MCH services.	
Improve EPSDT developmental screening, especially in area of social-emotional development.	Revise EPSDT developmental screening tools, and encourage all physicians to learn how to conduct developmental screening on all children and know where to refer children who are suspected of having a developmental delay	
Improve EPSDT developmental screening, especially in area of social-emotional development.	Train physicians to work with child care providers to help them diagnose possible problems, know where to refer these infants and understand how to interact with and care for children with disabilities.	
Preventing Texas infants and individuals aging out of children' s services from having to go into institutions due to lack of health care or community supports and services, and get institutionalized babies and individuals out	Work with CPS to teach them more about children with disabilities & special health care needs, how to assess their level of need, & how to help children remain in or relocate to the community -study infants in institutions, do report & recommendation	

Stakeholder Input (Women & Infants)		
Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Professional Training and Materials
Increase prenatal care during the first trimester for all women.	Increase support for the folic acid project and partner and train promotoras and other community health workers to deliver the message.	
Increase the number of low birth weight (< 3 pounds) infants and premature (<32 weeks of gestational age) infants receiving breast milk while in neonatal units and at time of hospital discharge.	Educate the medical community about the superiority of mother's milk over formula for babies less than one year of age and particularly for ill and premature.	
Reduce infertility in women of childbearing age by reducing chlamydia incidence and through improved chalmydia screening.	Education of health professionals regarding sexual history taking and counseling	
Decrease human papilloma virus infection especially in females.	Outreach to healthcare professionals for promoting primary prevention of HPV through Abstinence & fidelity and by promoting primary behavior change in sexually active males and females	
Decrease human papilloma virus infection especially in females.	Teach sexual health curriculum to promotoras across the state, starting with the border counties	
Increase father involvement in the health and well-being of their partners and children.	State will provide training to Title V recipients as to the benefits of involving fathers in the health care of their children and partners	
Reduce the incidence of premature birth in Health Service Region 4/5 North.	Provide materials and training to perinatal health professionals to recognize the scope of the problem and alert women under their care to the risk factors for premature birth as well as the signs of premature labor and what to do in an emergency.	
Reduce the incidence of low birth weight in Health Service Region 4/5 North.	Provide training and material to WIC Program staff on how to reduce the risk for low birth weight babies so that information can be included in educational presentations to WIC participants.	
Increase the proportion of pregnancies begun with an optimum folic acid level.	Continue to educate health providers on the importance of counseling women to take folic acid supplements or eat super fortified cereals	
Reduce the incidence of low birth weight in Health Service Region 4/5 North.	Provide low-literacy material to other programs working with low-income girls and women so that women clearly understand what will increase their chances of delivering a healthy weight baby	
Increase syndromic surveillance	Provide training for syndromic surveillance	
Need Increase support for breastfeeding mothers	Provide breastfeeding training and conference for physicians, nurses, and other health care providers in the community. Promote in all THS services	

Stakeholder Input (Women & Infants)		
Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Professional Training and Materials
Assist contractors with more personalized help to navigate the many rules and regulations to satisfy program requirements.	Provide contractors with inexpensive training opportunities. (i.e. no travel for them	
Reduce the incidence of premature births in Texas.	Educate health care professionals on preterm labor risk detection and preterm labor risk reduction and engage professionals in communicating the warning signs of preterm labor to pregnant women around the 20th week of pregnancy	
Decrease the infant mortality rate in the State of Texas	State to increase community awareness of infant mortality through hospital, provider, nurse training opportunities	
Increase the amount of substance abuse information that is presented to women during pre-natal visits.	State to develop an educational presentation for medical professionals that addresses substance abuse issues that can be easily delivered to women coming in for maternal childcare	
Reduce average age of pediatric hearing loss detection.	Continue education of pediatricians regarding risk factors from hearing loss and how it is related to delayed speech and language skills.	
Medical Home (see def. w.medicalhomeinfor.org) Every infant needs a medical home.	At the State level ask each pediatrician & family practitioner to take 5 to 10 children who need medical homes. You can do this voluntarily or if no response, make it a condition of licensure in this State. VFC for shots.	Access to Care
Increase the percentage of pregnant women receiving early and regular prenatal care.	Increase patient access to prenatal care by increasing the number of clinics available for indigent mothers. Increase private provider participation in the Medicaid program	
Increase accessibility of services for undocumented families, especially adults.	Provide written information to put into the hands of parents.	
Increase prenatal care in first trimester	Education and provide access to care	
Lack of access to family planning services for low-income women.	Hire more nurses and practitioners to open up slots in clinics for family planning services	
Increase the trimester of entry for prenatal patients.	Develop programs such as telephone and mobile unit screening to bring women into the care system more readily	
Need mammograms provided locally.	State to provide a mobile mammography unit to travel to the remote West Texas towns in our region	
Medical Home (see def. ww.medicalhomeinfor.org) Every infant needs a medical home.	Establish a 'Project Access' for children in every county. .Get info on how it was done from Dallas County Medical Society.	
Decrease the incidence of teenage pregnancy.	Increase the availability of reproductive health services for teens in the border area	
Decrease the incidence of STDs	Ensure the availability of services and medicines for the uninsured who are infected with STDs	

Stakeholder Input (Women & Infants)		
Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Access to Care
Reduce the incidence of premature infant births and low birth weight infant births.	Wider availability of prenatal care to Texas women (Topic Area 2), would decrease the incidence of premature infant births and low birth weight infant births	
Low Birth weight- Decrease the number of low birth weight infants being born.	Make prenatal care more accessible & less cumbersome to the parent	
Lack of access to family planning services for low-income women.	Expand services at university-linked clinics so patients can be seen without having to pay	
Need to have more medical providers available to see women and children.	More community-based or neighborhood clinics that will see walk-in patients.	
Decrease in the number of premature births	State to expand access to prenatal care through insurance packages for women who do not qualify for CHIP or MEDICAID	
Large numbers of new parents lack of basic parenting and child development skills and lack information or knowledge of how to access information that can benefit their child's health and development.	Expand and promote home visiting programs for new mothers.	
Support medical home concept for all children.	Promote medical home concept with physicians around the state	
Increase access to prenatal care for pregnant women in Texas.	Expand eligibility and streamline access to Medicaid and CHIP for pregnant women in Texas	
Increase access to prenatal care for pregnant women in Texas.	Expand available services through the use of nurse practitioners and certified nurse midwives in underserved areas.	
Preventing Texas infants and individuals aging out of children' s services from having to go into institutions due to lack of health care or community supports and services, and get institutionalized babies and individuals out.	Provide health and family supports - stop making it so difficult for families to access these services, address the resources needed to prevent/eliminate waiting lists, and revise practices currently preventing access to family supports	

Stakeholder Input (Women & Infants)		
Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Access to Care
Increase access to health care and family support services. Increase grants that allow Parent to Parent training and case management. Advocate for DSHS to find & fund a more appropriate program for services to individuals with CF when they turn 22.)	DSHS, the Governor and individuals with CF should meet to identify solutions to the continuation of health services, especially medication for adults with CF.	
Decrease the rates of overweight and obesity among young women.	Increase opportunities for young women to engage in group & individual physical activities, e.g., walking clubs for young moms, tennis lessons, support groups, classes at the Y, etc. Incorporate nutrition messages in the group activities.	
Decrease the rates of overweight and obesity among young women.	Increase worksite wellness programs where large numbers of young women work	
Provide more comprehensive services for this population, and access to recovery	Address the gaps in services that area rural; cover many miles, and square miles per capita. It appears most federal and state funds are targeted for metropolitan areas and there is more services for women and children.	
More research needs to occur to appropriate funds and services.	Address and study rural America	
Increase access to health care, including specialty services, in underserved and unserved areas of the state.	Evaluation/development of telemedicine infrastructure, incl. facilities, equipment, trained personnel, assistance for rural and outreach/satellite entities in identifying partners and negotiating agreements, patient and medical personnel education	
Increase access to health care, including specialty services, in underserved and unserved areas of the state.	Identification/utilization of successful models that educate medical students and local health providers and allow for their participation in specialty clinics and services (so that they can serve as extenders in underserved areas	
Increase access to PNC for the uninsured, especially Hispanic, Spanish-speaking women.	Increase state funding to clinics that serve the uninsured, especially pgt. Women	
Increase access to PNC for the uninsured, especially Hispanic, Spanish-speaking women.	Foster the Promotora model	
Increase the access to prenatal health and childbirth education for Spanish-speaking, immigrant women.	Partner with organizations that provide prenatal education in Spanish and make it available in a variety of forums that meet the needs of women at the community level	
PNC	Support more prenatal clinics in the community, especially in rural areas	
Increase prenatal care in first trimester	Provide access to care	

Stakeholder Input (Women & Infants)

Infrastructure Services

Suggested Needs/Activities from Stakeholders		Type of Service
Need	**Activity**	Access to Care
Increase prenatal care for young mothers.	Prenatal clinics through DSHS	
Develop a plan to attract healthcare providers in rural areas. Currently there is a lack of services for clients in many rural areas. This creates an additional need for assistance with transportation, and delay of services, etc. ALSO Undocumented clients have program access, but may not be able to access services that are outside of their hometown.	State assist in establishing outside health care resources and/or contractors to provide local access and services.	
Need	**Activity**	Contractor Issues
Assist contractors with more personalized help to navigate the many rules and regulations to satisfy program requirements.	Provide higher level of support with assigned DSHS staff to help contractor navigate compliance issues.	
Need Reduce the incidence of premature births in Texas.	Report prematurity data according to methods used by NCHS. Report prematurity in the Title V Annual report	Data issues
Decrease the number of infants exposed to drugs or alcohol during pregnancy.	Increase the number of healthcare institutions identifying and reporting local-level statistical data on the number of drug-exposed infants--it is difficult to address the problem when the scope of the problem has yet to be identified	
Increase the proportion of preschool children aged 5 years and under that receives vision screening.	Develop base-line data through community surveys	
Increase the number of low birth weight (< 3 pounds) infants and premature (<32 weeks of gestational age) infants receiving breast milk while in neonatal units and at time of hospital discharge.	Support existing Mother's Milk Banks in Austin and Fort Worth and establish additional banks in south and west Texas to increase the distribution of donor milk statewide.	Funding
To increase access to health care for pregnant women seeking pre-natal services.	Increase funding through Title V for prenatal care for undocumented pregnant women	

Stakeholder Input (Women & Infants)		
Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Funding
Increase the trimester of entry for prenatal patients.	Increase funding to expand clinic hours and satellite sites	
Breast cancer awareness and detection for women 40-64 years of age and those younger if indicated.	Development of a plan to provide these women funds for payment for mammograms	
Increase the availability of local resources for dental and primary health care services for low income residents in counties served by regional clinics	State could contract with local dentists to provide services to Title V-eligible women and children	
Provide primary care at the local level through contracts with local physicians or clinics. (Need Increased access to primary care services for Title V eligible clients.	Provide primary care at the local level through contracts with local physicians or clinics	
Transportation is a critical issue in Williamson County and the major barrier to care for both mothers and infants	Transportation grants for artery-based mass-transit in Williamson County.	
Improve the number of women getting prenatal care in the first trimester, improve compliance with follow-up postpartum care, infant care, infant development and reduce repeat teen pregnancies, reduce child abuse, especially in high risk populations.	Provide funding for a Doula program for pregnant teens and their children. This program is a lay health advocate program to help pregnant teens and new mothers cope with parenting and life changes for families with children up to age	
Low birth weight infants that survive long, costly stays in neonatal intensive care subsequently experience increased rates of emergency department visits, hospitalizations and pediatric ICU status during the first years of life.	Expand funding for culturally sensitive health education, support and social work services to parents of low birth weight children, including bilingual services. Provide formal infant mental evaluation and follow-up and nutrition/dietetic services.	
Improve quality and duration of breastfeeding in underserved populations through support for lactation consultant programs.	Support of breastfeeding initiatives in the hospital by funding of lactation consultants; Support of early follow-up programs linked to primary provider visit.	

Stakeholder Input (Women & Infants)

Infrastructure Services

Suggested Needs/Activities from Stakeholders		Type of Service
Need	**Activity**	Funding
Inherent difficulty in case management and follow up in this high-risk population	Increase funding for case management.	
Diabetes and Obesity rates countywide based on Diabetes Prevalence in Texas 2001 report.	Funding support in implementing countywide diabetes education initiative consisting of structured 8 week curriculum series along with monthly support group sessions.	
Mental Health services for pregnant and early interconceptional women.	Reinstatement of legislative funding for Medicaid mental health coverage.	
Assess to prenatal health care for low income women determined ineligible for Medicaid.	Increase in legislative funding to provide services through special programs.	
More funding for prevention of unplanned pregnancies would do more than any other one activity to decrease mortality and morbidity related to women's health.	Increased state funds for family planning.	
Need to have more medical providers available to see women and children	Incentives to new providers	
Dental care	Increase payment to providers	
Poor nutrition in prenatal patients.	Increase resources for general nutrition services at clinics.	
Need for bilingual classes in the area of childbirth preparation, newborn care, postpartum care, and family planning methods.	Community resources to send patients for learning or training available to our current staff to learn.	
Decrease the number of women who enter prenatal care during the 2nd and 3rd trimester. Decrease exposure to environmental contaminants. Increase the number of children accessing wellness clinic (THS), breastfeeding, & immunizations thru WIC clinics.	Increase funding for prenatal and wellness services in the local community, (assure that WIC continues to immunize).	

Stakeholder Input (Women & Infants)

Infrastructure Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Funding
Decrease the number of women who enter prenatal care during the 2nd and 3rd trimester. Decrease exposure to environmental contaminants. Increase the number of children accessing wellness clinic (THS), breastfeeding, & immunizations thru WIC clinics.	In collaboration with DSHS, seek other revenue sources, public or private, that may supplement the current funding.	
Increase syndromic surveillance.	Provide funding for syndromic surveillance, (surveillance using health-related data that precede diagnosis and signal a sufficient probability of a case or an outbreak to warrant further public health response).	
Decrease the infant mortality rate in the State of Texas.	Support of fiscally-neutral state legislation to facilitate the creation, authority, and protection of Fetal-Infant Mortality Review (FIMR) teams in Texas	
Provide adequate funding for mental health services for pregnant and postpartum women to support and assist providers comply with the Texas Legislature HB 341, Parenting and Postpartum Counseling Information.	Expand Medicaid reimbursement to include psychologists and LPCI's providing depression counseling and/or treatment.	
Provide adequate funding for mental health services for pregnant and postpartum women to support and assist providers comply with the Texas Legislature HB 341, Parenting and Postpartum Counseling Information.	Continue/expand Medicaid coverage to postpartum women suffering from depression until after counseling and/or treatment is completed. (Possibly by a Medicaid Waiver.)	
Increase the rates of breastfeeding, both initiation and duration.	Reactivate the TDH breastfeeding consortium, review the plan development by the consortium, determine what progress has been made, and identify next steps. This will require funding.	
Increase the rates of breastfeeding, both initiation and duration.	Make community-based breastfeeding interventions focusing on increased duration a priority for Title V population-based funding.	
Increase breastfeeding in the early postpartum period to 75%.	Continue to support and fund breastfeeding programs across the state.	

Stakeholder Input (Women & Infants)

Infrastructure Services

Suggested Needs/Activities from Stakeholders		Type of Service
Need	**Activity**	Funding
Better re-imbursement for advanced audiological services from TDH-PACT.	At state level, reimbursement rates for ABR could be increased, a rate for ASSR could be established and OAE could be established, in addition to a rate for ear mold impressions sessions and counseling sessions.	
Decrease health disparities among minority women.)	Increase availability and affordability of health screenings and services at local health department clinics.	
Provide more comprehensive services for this population, and access to recovery.	Appropriate funds, education, and means to address this underserved population (substance abuse).	
Improve the availability of specialized addiction treatment services for women, particularly those that treat pregnant women and women with infants and young children.	Refer and pay for comprehensive services at addiction programs that specialize in pregnant women and children.	
Increase awareness for importance of health screenings and immunizations.	Provide more money to make available grass roots awareness of importance of preventative care.	
Increase health coverage for infants / pregnant women.	Add more money to CHIP program and Medicaid to serve more infants / pregnant women.	
More OBGyns needed in rural counties-More hospitals that deliver babies, especially in Region 2. More low-cost or sliding scale preventive prenatal care, as well as more quality, low cost or free clinics for children. Transportation is a concern.	Work with Feds and local areas to find funding for Federally Qualified Health Centers.	
More women need to breastfeed for the health of their infants, and themselves, if not for financial reasons. We need to continue to work on changing this to make breastfeeding the societal norm. This would help the obesity problem, also.	More funding for education of health care workers, physicians, and the public.	

Stakeholder Input (Women & Infants)

Infrastructure Services

Suggested Needs/Activities from Stakeholders		Type of Service
Need	**Activity**	Funding
Develop a plan to attract healthcare providers in rural areas. Currently there is a lack of services for clients in many rural areas. This creates an additional need for assistance with transportation, and delay of services, etc.	State to enhance current services with additional funding.	
100% of prenatal clients deliver using emergency Medicaid with intent to have infants followed privately but fail to F/U with eligibility papers thusly leaving the infants without any payment source; 2 weeks blood test &well child ed, interventions.	Reinstate with funding-Title V in 4 county clinics to provide well child services.	
Prenatal clients financial resources to pay for additional laboratory bills, medications, diagnostic tests, and extended high risk care, especially gestational diabetes care and equipment is cannot meet the demand for expenses incurred and Title V funds.	Increase DSHS funded lab work, provide stock supplies and issue centrally, contract with hospitals for diagnostic tests.	
Increase access to health care and family support services. Increase grants that allow Parent-to-Parent training and case management. Advocate for DSHS to find & fund a more appropriate program for services to individuals with CF when they turn 22.	DSHS should advocate for the appropriate level of funding for CSHCN to maintain timely access to health services, to provide case management (including grants for Parent Case Management), and to expand family support services	
Nutritional counseling	Increase financial support for nutritional counseling	
Young children and adult high incidence of unhealthy eating habits and obesity.	Hold classes and require attendance for healthy nutritional programs before receipt of State/Federal Aid	
Breastfeeding	Support lactation consultants, including promotoras	

Stakeholder Input (Women & Infants)

Infrastructure Services

Suggested Needs/Activities from Stakeholders		Type of Service
Need	**Activity**	Funding
Increase percent of women receiving early PNC beginning in the first trimester.	The State to increase more funds at the local level for indigent prenatal care.	
Increase immunization rates among young children.	Ensure funding for low cost immunization	
Transportation in rural areas for health care services.	State to allocate monies for rural counties to implement transportation services	
Increase the number of providers seeking newborns, children and pregnant women.	Pay providers in a timely manner	
Decrease the percentage of women receiving late or no prenatal care.	State to provide funding for community based educational programs directed to minority and low-income WCBA regarding the importance of early prenatal care.	
Support medical home concept for all children.	Fund some pilot projects related to medical home.	
Decrease the incidence of birth defects in Texas.	Maintain or expand Title V and other funding sources for statewide birth defects surveillance in Texas.	
Need Increase the number of substance abuse treatment beds available for mothers with children.)	State to increase funding for substance abuse treatment beds for mothers and increase the number of children that can be allowed into treatment.	
More OBGyns needed in rural counties-More hospitals that deliver babies, especially in Region 2. More low-cost or sliding scale preventive prenatal care, as well as more quality, low cost or free clinics for children. Transportation is a concern.	Work with medical schools and Fed. programs to give more incentives to doctors to practice in rural areas.	Providers
Improve case management and timely follow-up service delivery by implementing a seamless referral process from Title V programs to DARS-ECI and other community-based providers.	Use TEHDI's web-based system in other newborn public health programs (genetic, birth defects) for case management and referrals to local providers	Access to client records
Improve case management and timely follow-up service delivery by implementing a seamless referral process from Title V programs to DARS-ECI and other community-based providers.	Give the medical home real-time and secure access to the patients' public health data records via a web-based system such as TEHDI's.	

Stakeholder Input (Women & Infants)

Infrastructure Services

Suggested Needs/Activities from Stakeholders		Type of Service
Make Title V data integrated and real-time via web-based reporting and tracking. Data integration eliminates submission duplication, improves data quality.	Implement data sharing guidelines among Title V programs to provide better services to Texans. Use TEHDI's web-based system as the tool to integrate.	Access to client records
Make Title V data integrated and real-time via web-based reporting and tracking. Data integration eliminates submission duplication, improves data quality.	Pilot integrating data collection at the hospital level using TEHDI's web-based system to eliminate data submission duplication. Same baby, same information but different submission systems currently used.	
Increase the number of providers seeking newborns, children and pregnant women.	Make the process of application for the patients easier and more timely (ie Medicaid office slow in processing applications)	Operations
Reform public assistance program.	Improve the transition process, to prevent them from quitting their job and going into the welfare system again.	
Health insurance [Medicaid, CHIP] for families.	Assistance to sign up for the available insurances.	
Health insurance [Medicaid, CHIP] for families.	Flexible hours for signing parents up for health insurance.	
Anemia and lack of appropriate nutrition.	Education of mothers of newborns on the importance of good nutrition for their developing infants and coordinating our efforts with the local independent school districts and county offices to identify and achieve this goal.	Collaboration/Coordination
Anemia and lack of appropriate nutrition.	Develop a system of referral for these mothers and infants so that when identified by one entity they will be informed of the other programs available to them through this joint effort between the hospital/clinic, ISD and the county health depart.	
Increase awareness for importance of health screenings and immunizations.	Develop better tracking system of health services and make information available between state agencies.	
Prenatal clients financial resources to pay for additional laboratory bills, medications, diagnostic tests, and extended high risk care, especially gestational diabetes care and equipment is cannot meet the demand for expenses incurred and Title V funds.	Have buy-in from county commissioners for support of extended services to PN to decrease end $$ spent if infant has bad outcome. Contract with high-risk provider to monitor clients.	Collaboration/Coordination

Stakeholder Input (Women & Infants)

Infrastructure Services

Suggested Needs/Activities from Stakeholders		Type of Service
There needs to be a concentrated effort to increase the number of children through the current Medicaid eligible age of one year who receive required vaccines and well child examinations.	Stronger coordination between local Health Departments and pediatricians, obstetricians and family physicians as well as Medicaid administrative agencies in order to ensure that children receive all required vaccines and exams.	
Increase father involvement in the health and well-being of their partners and children.	State to bring together agencies that are reaching out to fathers (Head Start, TCFV, WIC) together with Title V agencies to collaborate and plan joint activities	Collaboration/Coordination
Increase percent of women receiving early PNC beginning in the first trimester.	Coordinate Medicaid eligibility with pregnancy test sites so PNC can begin as early as possible	
Women's Health particularly in the area of family planning among teens as well as women within childbearing ages.	Continued outreach and coalition building on issues related to women's health including coordination with the new Center of Excellence on Women's Health at the University of Texas Health Science Center at San Antonio.	
A concern related to the need for expansion of Medicaid benefits to women who currently do not qualify.	Continue coalition building that can focus on reducing duplication of effort, sharing of resources including funding, facilities and professional staff.	
Reduce average age of pediatric hearing loss detection.	Audiologists could collaborate with pediatricians to help them detect and connect their hearing impaired patients by providing weekly screening clinics in our office, in the pediatricians' office or at the hospitals.	
Decrease the incidence of STDs.	Improve studies on contacts and coordination of STD services with providers in Ciudad Juarez.	
Decrease the incidence of late or no prenatal care among women residing in counties served by PHR 6/5 South clinics.	Investigate the feasibility of DSHS contracting with local community resources to provide ultrasound and high risk prenatal care for low income women	
Increase the availability of local resources for dental and primary health care services for low income residents in counties served by regional clinics.	Work with local coalitions and stakeholders to identify possible resources within or near the community willing to provide some low cost dental care for clients in need.	
Decrease the number of women of childbearing years abusing drugs and alcohol.	Increase referral of substance-using women of childbearing years to appropriate intervention services.	

Stakeholder Input (Women & Infants)

Infrastructure Services

Suggested Needs/Activities from Stakeholders		Type of Service
Need to reduce the amount of violence against women and children.	Increased community social programs to reduce the rate of family violence counseling, shelters, childcare and other supportive services.	Collaboration/Coordination
Increase the percentage of pregnant women receiving early and regular prenatal care.	Provide education in schools and health care facilities regarding the importance of prenatal care. Offer incentives, such as user-friendly information about babies, parenting, community resources, as an incentive to attend prenatal appointments.	
Increase the percentage of pregnant women receiving early and regular prenatal care.	Provide education in schools and health care facilities regarding the importance of prenatal care. Offer incentives, such as user-friendly information about babies, parenting, community resources, as an incentive to attend prenatal appointments.	
OBESITY---This is a growing epidemic in our State.	Parental education of mothers regarding nutrition for their infants/children is our best chance to stem this epidemic. Forming groups such as 'Healthy Dallas' that try to use existing community resources to reach parents where they leave to educate regarding the growing problems of obesity (see Dallas county Judge & Mayor Task Force as example)	
Decrease preterm birth rate	More effectively partner with a tertiary care center to reduce barriers to appropriate care upfront rather than after a potential intervention is missed.	
Inherent difficulty in case management and follow up in this high-risk population	Partner with local experts in disease management for patient care and follow up, minimizing duplicated visits and unnecessary travel.	
Decrease the language, cultural and geographic barriers to care that exist	Improve multicultural sensitivity by partnering with providers/institutions that have ability to address these issues, ie-social services, and translators.	
Increase the number of substance abuse treatment beds available for mothers with children.	State to continually follow and do research on best practices for pregnant women with substance abuse problems.	Best Practices
Decrease in the number of premature births.	State to identify quality perinatal education support programs with track record of improving outcomes and partner to 1) verify results, 2) develop implementation, and 3) evaluate outcomes and future plans. Best practice www.communitydoula.org.	
Need to reduce the amount of violence against women and children.	Improved social and economic climate in general.	General

Stakeholder Input on Women and Infants		
Domestic Violence		
Infrastructure Building Services		
Reduction of domestic abuse and violence.	State to work with law enforcement agencies in coordinated public campaign to address the rates of domestic abuse and violence in law enforcement bodies.	System Building
Population Based Services		
Decrease the incidence of children born ATOD affected, decrease low birth weight infants; decrease incidence of post-partum depression; prevent domestic violence.	Provide on-site substance abuse, mental health and domestic violence screening for all women.	Screening
	Cross train staff on domestic violence, substance abuse, mental health and child abuse and neglect	Training

Stakeholder Input (adolescents)		
Teen Pregnancy		
Infrastructure Building Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	
Reduce teen pregnancy in Hispanic youth, especially 1st and 2nd generation	Focus groups to better understand why and if is an area Hispanics themselves would like addressed and have ideas about.	Needs assessment, evaluation, planning
Decrease the rate of first pregnancies and subsequent pregnancies especially those at close inter-conceptual intervals among teens.	Increased funding for research that addresses the core issues leading to teen pregnancy including but certainly not limited to family violence, severe family dysfunction, depression and other mental health concerns.	Funding
Providers (MD's especially) not aware of laws around adolescent sexuality and pregnancy.	Conferences and guidelines more widely available and to encourage access to services	Training
Population Based Services		
Provide accurate, age-appropriate reproduction health care information to ALL kids.	• Include reproductive health in all science and health curriculums • Create a 'teen's health website' where kids can get frank information about reproductive health	Comprehensive Sex Education
Decrease the number of teens contracting a Sexually Transmitted Disease	Mandate schools to provide every middle school student with comprehensive sex education.	

Stakeholder Input (adolescents)

Teen Pregnancy

Population Based Services

Suggested Needs/Activities from Stakeholders		Type of Service
Need	**Activity**	Comprehensive Sex Education
Decrease the rate of birth for teenagers aged 15-17 years	Increased availability in the community (schools in particular) of birth control method information / abstinence education	
Decrease the incidence of teen pregnancy in Bexar County	• Encourage both abstinence and birth control information and education • Multiple strategies, encouraging abstinence, peer to peer education, providing contraceptive info and access	
Promote responsible behavior in teens.	• Increase education programs in schools to promote responsible behavior in teens • Develop mass media campaigns and telephone support lines to promote responsible behavior in teens	Youth Development/Resiliency
Minimal funding for structured after-school programs for middle and high school students	Work with schools to provide mentor programs and after school activities.	
Promote responsible behavior in teens.	State to move beyond abstinence only education programs to include also important information on sexuality and how to express it in a healthy manner. Healthy expression of sexuality has been related to lower incidence of depression and violence.	
Promote responsible behavior in teens	State to move beyond abstinence only education programs to include also important information on sexuality and how to express it in a healthy manner. Healthy expression of sexuality has been related to lower incidence of depression and violence	
Decrease the incidence of teen pregnancy in Bexar County	Improving overall outlook for teens by supporting programs that promote goal setting and increase self-esteem.	
Decrease the rate of first pregnancies and subsequent pregnancies especially those at close interconceptual intervals among teens which is related to the high rate of single parenting especially among teens and young adults.	Creative programs that rally each sector of community including public health, business, education, religious around the issue of teen pregnancy. To address one parent families now, partnerships must combine resources to address eminent needs.	

Stakeholder Input (adolescents)

Teen Pregnancy

Population Based Services

Suggested Needs/Activities from Stakeholders		Type of Service
Lack of family support and peer pressure also contribute to the increase number of teen pregnancy.	Enhance and develop programs to educate teens on sexuality issues, moral values, and family issues etc.	
Decrease teen pregnancy rate among Latinas in Odessa, Texas	Develop culturally sensitive training programs aimed at Spanish speaking parents to encourage more open and frank discussion between parent and child regarding sexual activity and risky behaviors; provide incentives for parental participation	Parenting/Parent Education
Decrease teen sexual activity.	• Provide education regarding parenting, pregnancy prevention including abstinence beginning in middle school. • Parenting classes	
Lack of family support and peer pressure also contribute to the increase number of teen pregnancy.	Enhance existing programs that educate parents/families on sexuality and family values	
Health and family planning education for adolecents	Improved health education that includes healthy sexuality as a main topic	Health Education
Provide accurate, age-appropriate reproduction health care information to ALL kids, beginning in about 5th grade.	Adapt health/human sexuality curriculums in middle schools that are prevention-based.	
Health and family planning education for adolescents	• Shift of public school educational priorites toward health education • Increase in legislative funding for health education	
Reduce the number of births to females 17 years of age and younger.	Collaborate with school districts to educate teens about teen pregnancy prevention.	
Decrease teen pregnancy rate among Latinas in Odessa, Texas	Provide in school training aimed at Latina girls about career options and future goal setting with an emphasis on how getting pregnant interferes with continuing education and planning for your career; provide incentives for student participation	

Stakeholder Input (adolescents)

Teen Pregnancy		
Population Based Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Decrease the incidence of STIs in school-aged adolescents in Texas.	Increase support systems within the community to support teens choosing abstinence.	Abstinence Education
Decrease the incidence of pregnancy among school-aged adolescents in Texas.	• Raise awareness of abstinence as a viable decision for adolescents by delivering educational programs to 50% of students and parents. • Increase the role of the media (print, TV, radio) in providing information on abstinence to Texas communities.	
Decrease teen pregnancy	• Outreach to healthcare professionals to promote abstinence in teens and young unmarried males and females. • Promote community-based programs that present abstinence as the societal standard for unmarried teens and young adults.	
Decrease teen sexual activity	Abstinence education in schools and the community.	
Direct Services		
Decrease incidence of teen pregnancy	Assure that birth control products are readily available.	Family planning services
	Facilitate family planning that includes contraceptives	
	Fund family planning programs that specifically target sexually active teens	
	Increased funding for family planning	
	Decrease incidence of teen pregnancy. Activity - Increase the percentage of teenagers receiving family planning services in local communities through education about available FP methods, service providers and encourage open and honest dialogue with parents.	
	Women's health family planning waiver	
Reduce recurrent teen pregnancies	Have pediatricians address contraception with teens of reproductive age and address contraception and gynecologic follow up with teen mothers at well child check ups more	

Stakeholder Input (adolescents)		
INCIDENCE OF STIs AMONG ADOLESCENTS		
Population Based Services		
Decrease the incidence of STIs in school-aged adolescents in Texas Activity	Educate community members about the consequences of STIs.	Community Education
Decrease chalmydia infection in adolescents and young adults	Provide online screening tools that are based on CDC screening and treatment guidelines.	Professional Education
Decrease the incidence of STIs in school-aged adolescents in Texas	Restore funding to The Worth the Wait program.	Abstinence Education

Stakeholder Input (children & adolescents)				
Infrastructure Services				
Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Access to Care
Healthcare Access	Pay providers a decent amount of reimbursement & pay it on time without major harassment	X	X	
Healthcare Access	Hire enough qualified people to answer provider questions without extended wait times	X	X	
Substance Abuse	Provide more in-depth education on the damage of alcohol		X	
Nutrition	State undertake campaigns to promote fitness for youth & reduce access to unhealthy foods in schools	X	X	
Nutrition/Diabetes	State can work with health care providers to educate parents about how to reduce risk of diabetes for their children	X	X	
Nutrition	State bring together agencies which conducts outreach to fathers (Head Start) to collaborate & plan joint activities	X	X	
Parenting	State provide training to Title V recipients as to the benefits of involving fathers in the health care of their children	X	X	
Teen Pregnancy Prevention	Require providers to provide education via Medicaid regarding "at-risk" sexual behavior		X	
Substance Abuse	Develop programs relating to alcohol abuse & law enforcement		X	
"At-Risk Behavior"	Teach parents & youth better coping skills regarding the consequences of high risk behavior		X	Health Education
Traffic Safety	Public service announcements bicycle helmets, stranger safety, sports pads, seatbelts & booster seats	X		
Traffic Safety	School programs that require parents to attend traffic safety training	X		
Traffic Safety	Increase education to children & parents about the dangers of inhalant abuse- target population *deaf*	X	X	
Substance Abuse & STDs	Educational activities- target population *deaf population*	X	X	
Reproductive health	Require reproductive health in all science and health curriculums	X	X	
Reproductive Health	Create website where teens can access	X	X	
Parenting Education	Increase funding for child abuse programs	X		
Parenting Education	Create mentoring programs who "at-risk" factor for child abuse	X		
Suicide Prevention	Develop or identify suicide prevention program for schools	X		

Infrastructure Services

Suggested Needs/Activities from Stakeholders				Type of Service
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Health Education
Infectious Disease	Educate parents on West Nile Virus	X	X	
Nutrition/Obesity	Encourage restaurants to offer low calorie & low fat options on children menus	X	X	
Suicide Prevention	Provide suicide prevention programs & educational materials for secondary schools	X	X	
Sexual Education	Mandate comprehensive sexual education at the middle school level & age appropriate education at the elementary level	X	X	
STDs	Create posters for middle schools which provide STD education	X		
Dental Services	Have state legislature to mandate the allocation of funding for dental services in rural areas and schools	X		Access to Care
Dental Services	Increased Medicaid dental rates	X		
Dental Services	Reinstate CHIP dental benefits to encourage more dental providers	X		
Mental Health	School districts ability to employ more qualified counselors &/or LPC's	X	X	
Healthcare Access	Recruit more CSHCN providers- target population *CSHCN*	X	X	
Teen Pregnancy	Utilize local experts in the care of high risk teen pregnancy		X	
Obstetric/Gynecology/ Reproductive health	Require pediatrician to address birth control and reproductive health with teen moms		X	
Dental Services	Reinstate CHIP Dental health benefits	X	X	
Dental Services	Develop dental voucher system for those without dental insurance	X	X	
Mental Health	Provide more money for counseling/mental health services	X	X	
Mental Health	Provide more money for treatment centers and hospitals	X	X	
Physical Activity	Put more money in after school programs to increase physical activity	X	X	
Nutrition	Develop more aggressive dietary educational campaigns for children & parents	X	X	
Healthcare Access	CHIP –"Tell every state representative and advocate who listen that the change is essential"	X	X	
Mental Health	Reaching out to younger "at-risk" youth		X	
Healthcare Access	GCC will bring medical & mental health care to the schools as an integrated component of FQHC services		X	
Physical Access	Implement after school programs which includes physical activity (for elementary & middle) schools	X	X	

Teen Pregnancy	Evaluate CPT code usage and cost association to determine the cost associated with case management of high risk teen pregnancy		X	
Healthcare Access	Improve coverage through CHIP, Medicaid & other health insurance mechanisms	X	X	
Infrastructure Services				
Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Access to Care
Women's Health	Expand funding for prenatal care provided to immigrants		X	
Needs Assessment	Develop baseline dated through community surveys	X	X	
Research/Teen pregnancy	Investigate literature for evidence of programs which have been successful in decreasing adolescent pregnancy & examine for replication feasibility in Region 7		X	
Research/Teen pregnancy	Collaborate with schools & faith-based centers in the development of strategies based on successful practice that will target adolescent population and reduce incidence of teen pregnancy		X	
Research/Teen pregnancy	State should provide education on healthy eating habits and exercise		X	
Sex Education	Need for education in middle & high schools		X	
	After school nutrition program	X	X	
State Education System	Increase school activity	X	X	
Substance Use/Abuse Enforcement	Stricter sanctions against parents who permit/allow underage drinking	X	X	
Physical Activity	Increase daily exercise/activities for children during and after school hours	X		
Teen pregnancy	Encourage pediatric providers to provide reproductive health during well child visits		X	
Public Health	Forums to address the impact of not providing public health services	X	X	
Physical Education	Policy changes in physical education in child care facilities & schools	X	X	Health Education
Nutrition	Require nutritional classes for parents in day care facilities (free) and schools	X	X	
Human Sexuality/ Family values	Enhance existing programs that educate parents/families on sexuality & families values		X	
Human Sexuality/ Moral values/family values	Enhance & develop programs to educate teens on sexuality issues, moral values & family issues		X	
Abstinence Education	State obtain funding to support programs on abstinence		X	
Healthcare Access	Increased availability of services in community schools		X	
Nutrition & Physical activity	Collaborate with school to promote a coordinated program designed to encourage physical activity and better dietary choices	X	X	
Nutrition & Physical activity	Promote policies & environmental changes that support healthy eating habits and physical activity		X	
Teen pregnancy Prevention	Collaborate with school districts to educate teens about teen pregnancy prevention		X	

Nutrition	Reduce calories from sugar and fat from school cafeterias and vending machines	X		
Physical Activity/Nutrition	Mandate physical education classes from kindergarten to 12th grade	X	X	
Nutrition	Mandate nutrition education & counseling in schools from kindergarten to 12th grade	X	X	
Infrastructure Services				
Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Health Education
Dental Care	Legislation mandating dental care under CHIP	X	X	
	Increase funding for MCH activities	X	X	
Substance Use/Abuse	Work with alternative schools & community based programs in addressing chemical dependency education		X	
Prenatal care	Utilize experts in the care of high risk teen pregnancy		X	
Criminal Justice	Increase funding for prevention and early intervention programs		X	
Criminal Justice	Develop structured science-based curricula and enrichment activities		X	
Healthcare Access	Develop programs to promote awareness of contraceptives & prevention of STDs for teens		X	
Substance Abuse	Increase education programs for schools		X	
Professional Development	Develop mass media campaigns and telephone support quit lines		X	
Professional Development	Provide online screening tools that are based on CDC screening and treatment guidelines		X	
Physical Activity	Add play grounds to the present community gardens project to allow safe area for children while the parents are involved in gardening and harvesting	X	X	School-based Health
Physical Activity/ Nutrition	Mandate physical activity/education classes at all grade levels and colleges, including private schools and day care centers	X	X	
Nutrition	Nutrition classes mandated for all health professional licensed	X	X	
Immunizations	Immunization media campaign	X	X	
Immunizations	Continue IMTRAC	X	X	
Teen Pregnancy	Develop culturally sensitive sex education material for the Hispanic population		X	
Teen Pregnancy prevention	Provide programs for Latino girls (self-esteem) w/ incentives		X	
Teen Pregnancy Prevention	Increase funding to research teen pregnancy		X	
Teen Pregnancy Prevention	Public health interventions through patient navigation and more traditional case management approaches	X	X	
Nutrition/Physical Activity	Community based programs such as STEPS to a healthier US	X	X	
Physical Activity	Offer extended after-school programs between 4 PM – 8 PM		X	
Physical Activity	Develop structured enrichment activities		X	

WIC/Prenatal	Expansion of WIC services, outreach into communities (churches etc) to inform patients about the importance of good nutrition		X	Outreach

Infrastructure Services				
Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Outreach
Adolescent sexuality & pregnancy	Conferences, guidelines more widely used		X	
Nutrition/Physical Activity	Promote evaluation of obesity programs to assess what works "evidence-based"	X	X	
Healthcare Access	Increase role by local state health departments to evaluate barriers, develop action committee and address the barriers individually, to improve service accessibility to those community	X	X	Access to Care
Substance Abuse	Develop and deliver a coordinated statewide substance abuse prevention effort in all schools while continuing with current efforts	X	X	
Substance Abuse	Implement statewide task force to look at substance abuse prevention in a public health model with all other disease risk for adolescents	X	X	
Nutrition	Work with school Health Advisory Councils to determine appropriate interventions to prevent & reduce obesity in school age east Texas children	X	X	
Nutrition/Physical Activity	Promote awareness of obesity as a public health problem, working with community coalitions to develop healthier & safer environments which promotes active living and healthy eating	X	X	
Nutrition	Provide assistance to schools in determining appropriate interventions to encourage greater fruit & vegetables consumption during meals at school	X	X	
Nutrition	Provide training & materials to after school care agencies to encourage children to snack on fruit while in their care	X	X	
Nutrition	Provide training and materials to youth leaders and adult mentor regarding the importance of adequate calcium for good health	X	X	
Adolescent Health Care Professionals	Encourage or provide incentives for medical providers to specialize in adolescent health		X	
Healthcare Access	Keep applying for grants and do not focus on 'medical home' but services such as Medicaid	X	X	
Nutritional	Develop multi-media parent messages that will break the cycle of nutritional neglect among infants & children	X	X	
Nutrition	Work with youth in a variety of settings promoting healthy ideas for incorporating more calcium in their daily food intake	X	X	Health Education

Nutrition/ Physical Activity	Increase amount of physical education children participate in at the elementary, middle & high school grades per legislative directive to all public and private school	X	X	
Nutrition	Direct all Title V Population-based state funding to go toward decreasing the incidence of obesity in Texas children & families	X	X	

Infrastructure Services				
Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Health Education
Nutrition Physical Activity Research	Increase support & availability of funds to augment community endeavors such as Children's Nutrition & Physical Activity Expo	X	X	
Abstinence Education	Raise awareness of abstinence as a viable decision for adolescents by delivering educational programs to 50% of students and parents	X	X	
Abstinence Education	Increase the role of media in providing information on abstinence in Texas		X	
Abstinence Education	Increase support systems within the community to support teens choosing abstinence		X	
Healthcare Access	Use TEHDI's web-based system in other Title V programs for case management and referrals to local providers	X	X	
Healthcare Access	Give the medical home real-time and secure access to the patient's public health data records via a web-based system such as used by the TEHDI program	X	X	
Healthcare Access	Implement data sharing guidelines among Title V programs to provide better services to Texas. Use TEHDI's web-based system as the tool to integrate.	X	X	
Healthcare Access	Pilot integrating data collection using TEHDI's web-based system to eliminate data submission duplication.	X	X	
Physical Activity Research	Advocacy for increased requirements for physical activity in physical education curricula for middle and high schools	X	X	
Nutrition Physical Activity Research	Fund research activities for cohort and intervention studies on obesity	X	X	
Health Education	Increase in legislative funding for health education		X	
Adolescent Health	Increase the number of "teen friendly" clinics staffed by adolescent medicine specialist in Texas		X	Access to Care

Prenatal/Adolescents	Approve legislation that would amend the statue related to tobacco warning signs to include language about the links between smoking and premature births		X	
Advisory Committee	Family/Consumer Advisory Boards		X	
Mental Health	Actively seek additional general revenue for community mental health authorities and ensure that it is targeted funding for children	X	X	
Mental Health	Ensure that there is an adequate number of children's mental health specialists	X	X	
Health Professional Training	State to develop and deliver training to promotora/community outreach to reach minority low income families regarding overweight/obesity, nutrition, exercise and other healthful behaviors	X	X	
Abstinence /Sex Education	Promote multiple strategies encouraging abstinence, providing contraceptive information and access		X	

Infrastructure Services				
Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Access to Care
Health Education	Educate elected officials regarding the detrimental consequences for the children and their health status	X	X	
Youth Development	Improving the overall outlook for adolescents by supporting programs that strengthen families, promoting self respect, development of self-esteem, and goal setting	X	X	
Health Education	Support programs that encourage family strengthening to prevent children entering the system	X	X	
Stakeholder Input (children & adolescents)				
Direct Services				
Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Access to Care
Healthcare Access	Co-location of services for pregnant & parenting teens	X	X	
Family violence/ child abuse	Screening & referral services regarding family violence & child abuse	X	X	
STDs	Provide local phone number for confidential STD testing	X		
Mental Health	Agency provide centers for all socio-economic students with substance abuse		X	
Mental Health	Juvenile probation offices hire license chemical dependency counselors to assist school districts	X	X	
Healthcare Access	Reimburse providers at an increased rate to encourage provider participation	X	X	
Substance abuse	Add more treatment beds to chemical dependency facilities	X	X	
Healthcare Access	Attempts to limit the cuts in CHIP with in GCC until the change is made	X	X	

Healthcare Access	Provide a mechanism for eligibility & enrollment of school children and their families into CHIP	X	X	
Nutrition	Physicians need to prescribe that patients exercised 30 minutes/day and educate them on healthy eating	X	X	
Substance Use/Abuse	Extending existing services for substance use & abuse		X	
Dental services	Public school districts utilize dental hygienists to evaluate and treat clients in school-based dental clinics		X	
Family Planning/ Healthcare Access	Change laws to increase access for family planning services		X	
Immunizations	Training for staff on TWICES	X	X	

Direct Services				
Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Access to Care
Immunizations	Continue support to regional clinics & TVFC and add media & advertising	X	X	
Substance Abuse	Increase funding for adolescent treatment centers		X	
Healthcare Access	Increase access for low-income populations through grant funding		X	
Family Planning	Better preconceptual counseling at family planning visits		X	
Prenatal Care	State to identify quality perinatal education support programs (Best practice)	X	X	
Healthcare Access	State to increase reimbursement fees for Medicaid & CHIP providers		X	
Nutrition/Physical Activity	Initiate multidisciplinary clinics to address co-morbidities associated with obesity	X	X	
Healthcare Access	Address issue of medically understaffed providers via additional hiring incentives, development of medical training facilities, grow current state facilities	X	X	
Substance Abuse	Make available 50% more interventions and treatment programs in the state for adolescents already involved in substance use & not in school. This would involve the criminal justice system and outreach programs	X	X	
Substance Abuse	Increase the availability of qualified professionals by 50% to address substance abuse problems with adolescents	X	X	
Mental Health	Develop major adolescent health center or clinic with health related services for adolescents including mental health services		X	
Healthcare Access	Incentives for providers to provide evening and weekend care, perhaps increased reimbursement	X	X	
Healthcare Access	More walk-in clinics in neighborhoods	X	X	
Professional Training	Develop and deliver training on the relationship between nutrition & oral health to THSteps providers & Social Service agencies	X	X	

Family Planning	Increase funding for family planning		X	
Adolescent Health Care	Provide collaboration with focus on adolescent care		X	
Mental Health	State create one funding stream in providing mental health services	X	X	
Mental Health	State create funding initiative for coordinated systems of care statewide	X	X	
Mental Health	Coordinate mental health support in schools around student learning support centers	X	X	
Family Planning/Healthcare Access	Provide funding for birth control other than IM injections, include birth control pills & other methods		X	

Direct Services				
Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	

Teen Pregnancy	Involve parents in support groups to increase awareness if children's activities to promote participation???		X	
Physical Activity	Increase publication of safe walking trails to be distributed to communities		X	
Health Education	Community outreach at WIC or day care centers to help mothers realize importance of prenatal care		X	
Head Injuries	Provide education at schools and community organizations on the causes of head injuries and ways to prevention	X	X	
Physical activity	Organize community physical activities with financial incentives	X		Provide $ Incentive/ Increase
School-based Health	Provide incentives for school districts which provide school-base health clinics	X	X	
School-based Health	Provide incentives for health care providers to provide services at school-based health centers	X	X	

Stakeholder Input (children & adolescents)

Enabling Services

Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Access to Care
Health Access	Financial eligibility guidelines for Medicaid, CHIP & CSHCN should be expanded to premium rates	X	X	
Health Access	Eliminate waiting list on CSHCN- target population *CHSCN*	X	X	
Abstinence Education	Restore funding to "Worth the Wait" Program		X	

Stakeholder Input (children & adolescents)

Population- based Services

Suggested Needs/Activities from Stakeholders				**Type of Service**
Need	**Activity**	**Ages 6-12**	**Ages 13-21**	Health Education
Teen Pregnancy Prevention	State provide comprehensive sex education programs which includes abstinence	X	X	
Teen Pregnancy	Focus groups within the Hispanic population in understanding teen pregnancy		X	
Abstinence Education	Educate community members about the consequences of SIT's		X	
Physical Activity Research	Fund research projects to study current rates of in school physical activity in middle school and high school students; and study the effects of intervention programs on increasing physical activity in middle and high school students	X	X	
Breast feeding	Forbid health promotion items which encourages bottle feeding	X	X	Outreach
Breast feeding	Outreach campaigns for breast feeding	X	X	
Abstinence Education	Promote abstinence through effective community-based abstinence programs		X	

Abstinence Education	Promote community-based programs that present abstinence as the societal standard for unmarried teens and young adults	X	X	

Stakeholder Input (children 1-6 yrs)		
Direct Services		
Suggested Needs/Activities from Stakeholders		**Type of Service**
Need	**Activity**	Health Services for CSHCN
Increase newborn screening in Texas.	Expand access to health care for newborns diagnosed with birth defects, the long-term effects of prematurity and other special health care needs in underserved areas.	
Decrease the number of children with no health insurance	Eliminate the waiting list on CSHCN	
Increase awareness of the CSHCN Program in the general public and medical communities. Recruit more CSHCN providers. The CSHCN Program is not well known in the medical community or by the general public.	Reimburse providers at an increased rate to encourage provider participation. With the Increased local providers this should decrease the amount of funds needed for medical transportation.	
Increase access to health care and family support services. Increase grants that allow Parent to Parent training and case management. Advocate for DSHS to find & fund a more appropriate program for services to individuals with CF when they turn 22.	DSHS should advocate for the appropriate level of funding for CSHCN to maintain timely access to health services, to provide case management (including grants for Parent Case Management), and to expand family support services	
Maintain assessment for expected ranges and accomplishments for age appropriate skills	Reinstate the Title V funding to adequately cover the cost of professionals and support staff to provide hands-on assessments, interventions and referrals	Basic Health Services
Need to enhance accessibility of pediatric primary care providers by encouraging more evening and weekend office hours.	Incentives for providers to provide evening and weekend care; perhaps increased reimbursement? More walk-in medical clinics in neighborhoods	
Increase immunization rates among children 18 months of age and older.	Increase funding for staff in public immunization clinics	
Enabling Services		
Increase the rate of recommended vaccines to children 0 to 4 years old to 90%.	Work collaboratively with the WIC Program to assure all WIC participants (0-5 yr old) are current with the recommended vaccines	Coordination with Medicaid, WIC, and Education
Encourage community support of Success by Six program	Make CHIPS more user friendly to benefit youth	

Many students in area schools do not have a medical home. Many students are eligible for Medicaid and are not enrolled	Provide a mechanism for eligibility and enrollment of school children and their families into the Medicaid or CHIP program. Provide eligibility workers at such events as kindergarten round up, back to school sports physicals or school supply day	
	Enabling Services	
Large numbers of new parents lack of basic parenting and child development skills and lack information or knowledge of how to access information that can benefit their child's health, development and well-being	Expand and promote home visiting programs for new mothers	Family Support Services
Provide better mental health services for children	Provide more money for counseling services, mental health screening and awareness starting at early age.	
Increase immunization rates among children 18 months of age and older.	Offer incentives to families whose children at age 2 and above are fully immunized	
Improve case management and timely follow-up service delivery by implementing a seamless referral process from Title V programs to DARS-ECI and other community-based providers.	Use TEHDI's web-based system in other Title V programs for case management and referrals to local providers. Give the medical home real-time and secure access to the patients' public health data records via a web-based system such as used by the TEHDI program	Case Management
Population-based Services		
Decrease the number of children who are not ready to learn when they reach school	Increase the number of child care health consultants who can educate and train parents and caregivers on providing stimulating, safe and healthy environments and relationships to their children	Outreach/Education
Increase the number of children receiving childhood immunizations according to the recommended schedule	Increase home visiting and other outreach programs that educate parents in regard to the importance of immunizations. Routinely provide education to parents at the time of birth as well as when they are seen for acute illnesses Inform and educate the public about vaccines and vaccine-preventable diseases. Develop state-wide media campaign about importance of immunizations Provide outreach and information about vaccine preventable diseases, immunizations and community resources to locally identified underserved /underimmpopulations (for example, segments of non-English speaking Latino populations in Liberty County). Provide ongoing public awareness on TVFC Program	

Decrease the incidence of tooth decay resulting from inadequate nutrition in poor families, who have almost 5 times as much tooth decay as children of higher income families.	Develop multi-media parent messages that will break the cycle of nutritional neglect among infants and children. Babies don't' need sugar	
Increase the rates of long-term breastfeeding (LTBF, at least 6 months) thus improving nutritional habits of child and parents	Invest in outreach through 1) Breastfeeding Awareness Campaign organized by the DPHHS Office of Women's Health and the National Ad Council and2) work with schools and businesses to provide and promote breastfeeding facilities	
Level of obesity in children is high	Outreach in Head Start Programs and Early Childhood Intervention with parent education for nutrition. Physicians need to prescribe that patients exercise at least 30 minutes a day most days of the week and educate them on healthy eating Increase the implantation and promotion of the Walk Across Texas program in the schools and at the community level across the state. Required nutritional classes for parents of free day care agencies, and children in the schools Develop more aggressive dietary educational campaign for children and parents Nutrition education/counseling outreach program to work with families identified as high-risk. Program includes meal planning, shopping, and preparation of healthy foods. Incorporate into program behavior modification, hypnosis, meditation, biofeedback Organized community physical activities for individuals & families with participation rewarded by $, rebates, and / or tangible gifts. Regular nutritional education and counseling for K-12 grade students and parents should be part of the school curriculum during the year	
To increase the number of Medicaid and CHIP providers in Denton County	Local Medicaid and CHIP health plans to increase area network provider outreach.	
Decrease incidence of Type II diabetes in Hispanic youth	State can undertake campaign to promote fitness for youth and reduce access to unhealthful foods in schools. State can work with health care providers to educate parents about how to reduce the risk of diabetes for their children.	
Increase father involvement in the health and well-being of their partners and children	State will provide training to Title V recipients as to the benefits of involving fathers in the health care of their children and partners	
Increase the percentage of children receiving regular well-child care during the preschool years	Provide parents with education and outreach programs to emphasize the importance of completing routine well child checks	

Decrease the incidence and transmission of communicable diseases, such as west Nile and infectious staph aureus.	Educate parents on West Nile Virus infection prevention including one on one counseling, printed materials, educational presentations and local media Deliver prevention information to school nurses and other groups in the community identified as being at risk for outbreaks of infection with staph aureus.	
Encourage community support of Success by Six program	Develop PSA's to promote increased immunization through coalition efforts	
Increase the healthy eating practices of children served by the HIPPY program	Implement healthy choices programs to be provided in groups to parents, including cooking classes Early childhood materials, such as kits, bilingual, such as the Tufts University program developed with HIPPY USA, to be used with children in group settings	
Increase awareness of the CSHCN Program in the general public and medical communities. Recruit more CSHCN providers. The CSHCN Program is not well known in the medical community nor by the general public	Recruit more CSHCN providers. Contact 100% of medical care providers in a noticeable format. Promote public awareness through advertising.	
Children and families with mental health needs are isolated and stigmatized in their local community that eliminates access to vital informal supports and opportunities for building successful normative roles	Build local, regional and state initiatives around building communities that support access for all children and decrease the stigma of differences. Incorporate broad community participants including faith, commerce, scouting and others	
Maintain assessment for expected ranges and accomplishments for age appropriate skills	Support local entities in their development of outreach programs to identify children households in need of contact and interventions.	
Local safe areas that children can walk to and play or walking areas for parents to encourage family walking to increase activity levels in all member of household	Increase publication of safe walking trails and distribute to households, medical providers, hospitals, employment sites, and WCCHD clinical and WIC sites Add playground to the present community gardens project to allow safe area for children while parents are involved in gardening and harvesting	Injury Prevention
Decrease incidence of head injuries caused by preventable accidents in the Dallas area	Provide education at schools and community organizations (such as YMCA's etc) on causes of head injuries and ways to prevent (i.e. appropriate car seat usage, wearing helmets, etc.)	
Decrease the incidence of child abuse and neglect	Increase funding for prevention programs Consider developing a program to train successful parents to be peer mentors to families who have risk factors for child abuse or neglect. Support programs that encourage family strengthening to prevent children to enter the system Encourage male participation in preventive programs, especially for young males.	

Safety awareness - Bike helmets, stranger safety, sports pads, seat belt, and booster seats	PSA's made specifically to target this audience	
Screen for FASD identify and provide services for FASD infants and children	Screening of all infants and children	Screening
Decrease the rate of obesity in children (> 95th percentile BMI-for-age) between the ages 2 and 5 years	Weigh and measure children and assess the risk of the child becoming, or being, overweight	
Increase the proportion of preschool children aged 5 years and under who receive vision screening	Improve screening programs and access to these programs	
Decrease the rate of obesity in children (> 95th percentile BMI-for-age) between the ages 2 and 5 years	Counsel on nutrition and physical activity and healthy behaviors to maintain a health weight	Nutrition
Level of obesity in toddlers is high	Family centered nutrition classes (since much of family is obese with the target child).	
Infrastructure Building Services		
Ensure children with mental health issues have available a comprehensive array of services	Work to improve the array of mental health services for children in the Medicaid and CHIP programs	Systems of Care
The long-standing value of 'Community First' for children with special health care needs and disabilities must survive the newly reorganized DSHS	Hire and keep leadership in CSHCN who embrace 'Community First' values. Advocate for the CSHCN Advisory Committee function to be restored, at DSHS or as a component of another children's advisory committee. Maintain trust with advocates and within the HHSC system that CSHCN will support and implement the state's policy that children belong in families and continue to actively participate in the Children's Policy Council advisory process.	
Increase children and adolescents access to local healthcare services	Address issue of medically understaffed providers via additional hiring incentives, development of medical training facilities, and grow current state facilities.	
Increase immunization rates for 1-4 year olds	Convert dental van into immunization van and travel to areas of need Offer bonus' for DSHS offices that have > 90 % immunization rate	
Maintain ability of children and adolescents enrolled in STAR, STAR+PLUS and CHIP HMOs to obtain care at federally funded hemophilia treatment centers (HTCs).	Require STAR, STAR+PLUS and CHIP HMO plans statewide to include federally-funded HTCs in their provider networks to ensure access to expert hemophilia care	

Increase the number of providers taking Medicaid	Pay the providers a decent amount of reimbursement and pay it on time without major harassment Hire enough qualified people to answer provider questions without extended wait times. This will decrease frustration with the system.	
Increase father involvement in the health and well-being of their partners and children	State to bring together agencies that are reaching out to fathers, such as Head Start, Texas Council on Family Violence and WIC together with Title V agencies to collaborate and plan joint activities.	
Reduce uncorrected visual impairment due to refractive errors	Improve access to professional eye and vision care for all children	
Increase the percentage of children receiving regular well childcare during the preschool years.	Increase access of patients to well childcare through increasing the number of clinics and private providers serving Medicaid and CHIPS patients	
Increase the rates of immunizations among preschool aged children and infants.	Continue to conduct recall and reminder activities for immunization clients and encourage area providers to enroll in Immtrac and as VFC providers Continue to work with school district school nurses in becoming VFC providers to provide vaccine for school age children and thus increase available time for Region staff to focus vaccination efforts on the young child 0-35months	
Provide better mental health services for children	Provide more money for treatment centers and hospitals. There are few facilities that exist to stabilize these children that need mental health services. Local MH clinics to expand children services School districts to be able to employ more qualified counselors and / or LPCs Coordinate mental health supports in schools around student learning support centers. Blend and braid funds from all children serving agencies to support early intervention in school settings and focus on school and learning success. Blend initiative for learning supports with Texas Integrated Funding Initiative, build local and regional stakeholder oversight groups and integrate local school boards, teachers and school administrations, build parent partner positions into model	
Access to affordable dental care	Public school districts utilize dental hygienists to evaluate and treat clients in school-based dental clinic. Open a Su Clinical Familiar dental satellite office in Port Isabel	

Obesity / nutrition	Review and modify WIC program to emphasize / educate proper nutrition Increase support and availability of funds to augment community endeavors such as the Children's Nutrition and Physical Activity EXPO Increase amount of physical education children participate in at the elementary, middle, & high school grades per legislative directive to all public & private schools. Direct all Title V Population - Based state funding to go toward decreasing the incidence of obesity in Texas children & families. Resources could be directed toward this problem to see if the current contractors can make an impact. Mandated daily physical activity/education classes at all grade levels, including college, in all school districts, and including private schools and day care centers, if possible. Nutrition classes mandated for all health professionals in order to be licensed. At least one nutrition course, emphasizing weight control and maintenance, as a requirement for high school graduation, in addition to the 'health class' required. Policy changes in PE in the child care agency, schools Put more money in after school programs to increase physical activity. Make it mandatory for snack machines to be removed from school campuses At the state level state agencies need to get educated about healthy eating habits and exercise and administration should provide support such as having exercise rooms/equipment having a policy that all state functions should provide healthy foods Physical education should be reinstated and be mandatory for all children starting from kindergarten to 12 grade at all schools.	Policy Development
Large numbers of new parents lack of basic parenting and child development skills and lack information or knowledge of how to access information that can benefit their child's health, development and well-being.	Reinstate Take Time for Kids/Texas Tots/Building Blocks mail outs that provide developmental information to families at timely intervals (age paced so that parents receive issues appropriate to their child's age/developmental needs) - not in bulk	
State to increase reimbursement fees for Medicaid and CHIP providers.	To increase the number of Medicaid and CHIP providers in Denton County Financial eligibility guidelines on current Medicaid, CHIP and CSHCN Program should be expanded. Premium payment could be implemented for all programs based on income Legislation to providing dental care under CHIP Increase funding for MCH activities	
Improved funding, access and availability of culturally-appropriate mental health services for the children and their parents	Start truly open and inclusive forums and discussions with the public to identify alternative funding systems, including alternative taxation systems, and educate the public about the costs of not doing so, particularly lawmakers Actively seek additional general revenue for community mental health authorities, and ensure that there is targeted funding for children. Also, make sure that the agency has an adequate number of children's mental health specialists	

Increase the rates of long-term breastfeeding (LTBF, at least 6 months) thus improving nutritional habits of child and parents	Forbid the display, promotion and/or distribution of formula and bottles throughout healthcare system, especially ob/gyn and pediatric offices	
Decrease in the number of premature births	State to move beyond abstinence only education programs to include also important information on sexuality and how to express it in a healthy manner. Healthy expression of sexuality has been related to lower incidence of depression and violence	
Head start services for infants	State to expand Head start services to include infants to age 2	
Safety awareness - Bike helmets, stranger safety, sports pads, seat belt, and booster seats	School programs, hand outs and require parents to attend programs - LAW for boosters	
Decrease the number of children with lapses in health insurance coverage	Provide TRUE integrated eligibility so that only ONE APPLICATION is needed for ALL PROGRAMS Renew CSHCN coverage annually rather than bi-annually	
Increase benefit for dental health	Reinstate dental benefit in CHIP program. Develop dental voucher system for those without dental insurance. More dentists who will accept Medicaid	
CHIPS must be included in the PPS program for FQHC's in Texas. Without inclusion FQHC's will be forced to severely limit or eliminate CHIPS patients from their practices	Tell every state representative and advocate who will listen that this change is essential Attempt to limit the cuts in CHIPS patients within GCC until the change is made	
Expand funding for prenatal care provided to immigrants. Currently Parkland spends over $21 million on prenatal care to immigrants	Expand funding for prenatal care provided to immigrants	
Lack of access to a coordinated continuum of care for children with mental health needs. Per the surgeon general's report, there are likely 12,915 children living in Denton County with mental illness severe enough to cause functional impairments	State to organize all children's mental health funding into one funding stream that could be coordinated to allow dollars to move from more restrictive, out of home placements into more effective community system of care. State to fund coordination of local system of care and facilitate local and regional stakeholder oversight groups and training in systems of care through Texas Integrated Funding Initiative.	

Provide medical care, rehabilitation services, equipment, nursing, and attendant care support to all severely disabled children and their families regardless of income.	Make Medicaid waiver programs available to all eligible children without being on a waiting list for years and years. Streamline the Medicaid waiver programs to make access to the services consumer friendly, not consumer painful, time consuming and frustrating	
Increase access to health care and family support services. Increase grants that allow Parent to Parent training and case management. Advocate for DSHS to find & fund a more appropriate program for services to individuals with CF when they turn 22	Keep applying for grants and do not just focus on 'medical home'. Think about a grant to find and inform families of young children about how to use their Medicaid card to prevent institutionalization or provide services after leaving an institution.	
Decrease the number of children who are not ready to learn when they reach school.	Increase the number of physicians who participate in the Reach Out and Read program (which helps parents understand the importance of reading to their children, including infants, for success in school)	Training
Decrease the incidence of tooth decay resulting from inadequate nutrition in poor families, who have almost 5 times as much tooth decay as children of higher income families.	Develop and deliver training on the relationship between nutrition and oral health to THSteps providers and social service agencies that work directly with low-income families starting perinatally, continuing through the school-age years.	
Continue to promote immunizations for children.	Training for staff on TWICES	
Screen for FASD identify and provide services for FASD infants and children	Staff training in identification of and services for FASD	
Increase the proportion of preschool children aged 5 years and under who receive vision screening	Develop base-line data through community surveys	Needs Assessment
Reduce uncorrected visual impairment due to refractive errors	Develop base-line data through community surveys	
Reduce blindness and visual impairment in children and adolescents aged 17 years and under	Develop base-line data through community surveys	
Children and families with mental health needs are isolated and stigmatized in their local communities that eliminate access to vital informal supports and opportunities for building successful normative roles	Create uniform data collection across child serving entities and track costs of failure to support Texas children in increased school failure, residential placement, juvenile justice costs, youth violence, parental relinquishment of children; publish	

Reduce blindness and visual impairment in children and adolescents aged 17 years and under	Develop and make eye health education and health promotion programs available	Applied Research
Obesity / nutrition	Coalition building to educate through schools / daycare, etc	Coordination
Increase immunization rates in young children 0-35 months	Work with community birthing facilities to develop programs that would encourage and assist new moms in being compliant for accessing immunization services for infant. Develop programs to enroll children in medical homes	
Improved funding, access and availability of culturally-appropriate mental health services for the children and their parents	Improved coverage through CHIP, Medicaid and other health insurance mechanisms	
Preventing Texas children with special health care needs and disabilities from having to go into institutions due to lack of health care or community supports and services, and get institutionalized children out.	CSHCN work with CPS to teach them more about children with disabilities and special health care needs, how to assess their level of need, and how to help children remain in or relocate to the community.	
Decrease in the number of premature births	State to identify quality perinatal education support programs with track record of improving outcomes and partner to 1) verify results, 2) develop implementation, and 3) evaluate outcomes and future plans. Best practice www.communitydoula.org	Standards Development
Increase children and adolescents access to local healthcare services	Increased role by local state health departments to evaluate barriers, develop action committee and address barriers individually, to improve service accessibility to those in community	Evaluation
Make Title V data integrated and real-time via web-based reporting and tracking. Data integration eliminates submission duplication, improves data quality.	Implement data sharing guidelines among Title V programs to provide better services to Texans. Use TEHDI's web-based system as the tool to integrate. Pilot integrating data collection using TEHDI's web-based system to eliminate data submission duplication. Same baby, same information but different submission systems currently used.	Information Systems
Increase newborn screening in Texas	Appropriate an estimated $3.4 million for the 2006/2007 biennium's to cover the technology, staff and supplies needed to screen for the recommended 30 disorders in Texas.	
Improved immunization rates	Continuing to work on information technology to allow shot records to follow the child anywhere	

Needs Assessment

Attachment D

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	

8. Rate of birth (per 1,000) for teenagers aged 15 through 17 years				
• Government loans or grants being offered to small businesses that provide and promote family oriented activities in order for them to pass saving opportunities to their customers.	No		No	Not in the scope of Title V
• Increased legislative funding for health and family planning education in school	No		No	Not in the scope of Title V
• Making parenthood planning and education information accessible and part of a structured medical home is the best answer to this result.	No			
• Keep it down - Support Planned parenthood as well as abstinence education	Yes	Yes		
• Show more money involved in raising children	No		No	Resources are available for research and evaluation
• Remove requirement for parental consent from some programs	No		No	Not in the scope of Title V to remove legislation
• Mandatory parenting classes prior to being eligible to receive benefits.	No		Yes	
• Reinstate age-paced parenting/developmental information mailouts for parents of young children (Take Time for Kids/Texas Tots/Building Blocks).	No		No	Lack of Resources
• Fund successful community programs aimed at decreasing teen pregnancy rate.	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• All kids need accurate, frank, age-appropriate INFORMATION!	Partial	Yes		Resources do exist for this activity. Need to develop this funding opportunity.
• Comprehensive sex education and health in schools	No		No	Not in the scope of Title V Schools mandate curricula

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Mandate schools to provide every middle school student with comprehensive sex education.	No		No	Not in the scope of Title V Schools mandate curricula
• Increased availability in the community (schools in particular) of birth control method information / abstinence education	Partial	Yes		Abstinence Education is currently funded. Schools mandate curricula.
• Encourage both abstinence and birth control information and education	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• Provide multiple models including but not necessarily limited to abstinence plus models, parenting models and religious and school based models that include culturally sensitive and strong evaluation components.	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• the use and increased resources for programs such as Project WORTH abstinence programs.	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• Multiple strategies, encouraging abstinence, peer to peer education, providing contraceptive info and access	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• Provide education regarding parenting, pregnancy prevention including abstinence beginning in middle school.	No		No	School districts decide curriculum
• Increase abstinence programs at schools and after school.	Yes	Yes		
• Provide education of abstinence in schools	Yes	Yes		
• Abstinence education, in school and the community.	Yes	Yes		
• Promote community-based abstinence programs for teens and young adults.	Yes	Yes		

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Provide accurate information about condoms and contraceptives. Roughly 20% of teens using contraception (the pill or condoms) become pregnant within one year.	Yes	Yes		
• Partner with other agencies and groups on education promotion.	Yes	Yes		Resources do exist for this activity. Need to develop this funding opportunity
• Start sex education in elementary school age in group setting such as churches, community centers etc with parents participation.	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• Increased availability of after-school and evening community activities and programs for teens, especially for those teens who don't participate in extra-curricular activities at school.	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• More Community Based programs for adolescents that promote healthy self-esteems instead of sex and violence.	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• Improving overall outlook for teens by supporting programs that promote goal setting and increase self-esteem.	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• Work with schools to provide mentor programs and after school activities.	No		No	Resources do exist for this activity. Need to develop this funding opportunity.
• Educate teens about peer pressure, self esteem, sexual responsibility, impact of teen pregnancy and support grass root efforts among teens to delay initiation of sexual activity.	Yes	Yes		Resources do exist for this activity. Need to develop this funding opportunity
• Work with schools to provide mentor programs and after school activities.	No		No	Resources do exist for this activity. Need to develop this funding opportunity
• Comprehensive substance abuse program that includes sex practices when under the influence.	No		No	Title V could work with DSHS Substance Abuse Program

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Improved health education that includes healthy sexuality as a main topic	No		No	School districts decide curricullum
• Parenting classes	Yes	Yes		
• Assure that birth control products are readily available.	Yes	Yes		
• Facilitate family planning that includes contraceptives.	Yes	Yes		
• Fund family planning programs that specifically target sexually active teens.	Yes	Yes		
• Well, this may be very good in some areas, but we need to continue to improve in other areas of the state. Even 40 births to 1000 teens is too many.	Yes	Yes		
• Increase the percentage of teenagers receiving family planning services in local communities through education about available FP methods, service providers and encourage open and honest dialogue with parents.	Yes	Yes		
• Highest teen pregnancy rate in nation could be decreased with increased access to family planning.	Yes	Yes		
9. Percent of 3rd grade children who have received protective sealants on at least one permanent molar tooth				
• Increase reimbursement rates to attract local providers.	No			
• Educate elementary schools, specifically school nurses regarding dental health issues and benefits of dental sealants	Yes		Yes	Program revising web-base nurses manual, due to 75% cut in Dental Health Program budget considered best practice by the association of State & Territorial dental director
• Develop educational materials for school nurses to implement health education classes for 3rd grade classes.	Yes	Yes	Yes	Dental Health Program revising web-base nurses

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Develop educational materials for school nurses to educate parents during PTA meetings	No		Yes	Questionable as it relates to dental sealants Web based training could be used to educate parents
• Reinstate CHIP dental benefits.	Yes	Yes	Yes	
• Support initiatives that encourage dentist to participate in donated and low cost service provisions for low income families	No		No	**Yes** (Association of State and Territorial Dental Directors) Limited capacity Best Practice (ASTDD)
• Fund dental programs	Yes	Yes	Yes	**Yes** (Association of State & Territorial Dental Directors) Best Practice (ASTDD)
• Expand access to other insurance programs	No		No	
• Provide dental education in schools & dental	No		No	
• Fund direct delivery of school-linked or school-based dental sealant programs	No		No	
• Include dental hygiene education as part of core health curriculum in schools	Yes		Yes	**Yes** (Association of State and Territorial Dental Directors) Currently in Pre-K through 6th grade
• Initiate oral health campaign to include screenings, preventative care, education session and coordination of primary dental care providers for families.	No		No	
• Increase enrollment incentives for Medicaid dental providers	No		No	
• Mobile dental vans	Yes		Yes	Administered through RFP process
• Create a programs for FQHCs	Yes/No	Yes	Yes	
• Transportation for families in rural areas	Yes		Yes	Via THSteps
• DSHS partner with local agencies to provide dental sealant to all 3rd graders in rural communities via mobile dental Units	Yes	Yes	Yes	Best Practice ASTDD

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Utilize the Texas Dental Hygienist Association members to conduct free Saturday clinics in collaboration with public health dental clinics & THSteps	Yes	Yes	**Yes**	Texas Dental Hygienist Association (Association of State & Territorial Dental Directors)
• Increase educational awareness of the importance of proper dental care among infants and young children	No		No	
• Utilize current programs that promote hands-on children activities to promote dental care	No		No	
• Teach public health nurses and school nurses how to apply dental sealants	No		No	
• Dental funding reinstatement	No		No	
10. Rate of deaths to children aged 14 yrs and younger caused by motor vehicle crashes per 100,000 children				
• Parental education and support	Yes	Yes	Yes	
• Shattered Dreams program	Yes	Yes	Yes	Administrated by the Texas Department of Transportation (TXDOT) best practice NHTSA
• Increase public service announcements concerning drunk driving penalties and seat-belt safety	Yes		**Yes**	Regionally, targeting areas with the highest incidence done independently by local school districts (National Highway Traffic Safety Administration, NHTSA)
• Fund enforcement of safety seat laws	No		No	only educate and train
• Increase funding for personnel who educate and distribute safety seats	No		No	
• Provide school and community education on car seat safety	Yes		Yes	Best Practice (NHTSA) Conducted statewide
• Require all children < 100 4'9" tall to be in a safety seat	No		No	Current legislation requires height of 36' and 4 yrs of age 77 legislature Statewide
• Distribute child safety literature in health care provider offices, birthing classes, hospitals, etc.	Yes	Yes	Yes	Conducted Statewide
• Increase in contractors that provide outreach awareness services along with Texas Children's Hospital regarding on Care Safety/Seat Belt and Care Seat usage with children	Yes	Yes	Yes	Administrated through TXDOT

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Public awareness and education campaigns about utilization issues	No/Yes Texas Department of Transportation	Yes	Yes	Administrated through TXDOT
• Increase enforcement by police officers and the courts	No		No	
• Media Campaigns	No		No	
• Health fairs	No			
• Expansion and legislation of child fatality review teams	Yes	Yes	Yes	Administrated in a limited capacity
11. Percentage of mothers who breastfeed their infants at hospital discharge				
• Offer special recognition for hospitals staffed with Certified Lactation Consultants. (2 times	Partially	Y	Y	Good way of ensuring adequacy of information. Texas Ten Step (WIC) Consistent reliable source of info on BF
• Develop recognition program for hospitals, OB/GYN clinics, CBO's, etc. who promote breastfeeding and who have developed a plan to help reach the HP2010 objective of breastfeeding initiation.	Partially	Y	Y	Would continue that info & support beyond hospital. Texas Ten Step (WIC) Ensure that hospitals are providing good BF info & support
• Forbid unnecessary bottle-feeding and the display of formula and bottles in hospitals and pediatric offices.	N	N	N	Not in our scope. Legislative effort
• The state of Texas should support and enforce the WHO code on formula.	N	N	Maybe	Might reduce exposure to formula. Could cause backlash. Requires legislation
• State boards for physicians, RNs, LVNs, PAs, Nurse Practitioners should include competency on breastfeeding issues.	DK	NA	Y	Good way of ensuring adequacy of information. Not known to what extent they currently do.
• Incorporate a strong breastfeeding component in prenatal, and intra-partum care service delivery.	Partially	Y	Y	It represents the highest standard of care. Only WIC really has the means/mandate (ie: WIC)

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Home visits should be encouraged.	Partially	Y	Y	But, need to be able to guarantee safety. Also, potentially expensive. Easy access for moms.
• Provide incentives to hospitals to become 'baby-friendly.'	Y	Y	Y	Some type of financial incentive might be more effective. To ensure hospitals facilitate BF Texas 10 Step (WIC)
• Improved training of hospital staff and partnership with successful community-based breastfeeding organizations. (2 times)	Y	Y	Y	Good way of ensuring adequacy of information. Excellent training opportunities. (WIC)
• Continue to train perinatal health professionals on breastfeeding support; dispel myths and misconceptions about breastfeeding.	Y	Y	Y	Good way of ensuring adequacy of information. Excellent training opportunities
• Culturally sensitive education for para-professionals and peer providers such as promotoras and doulas addressing such issues as the positive impact of breast feeding, fears of new mothers and depression during the perinatal period.	Y	Y	Y	Very effective Peer Counselor Program (Not sure if fears depressionare addressed) (WIC)
• Target funding and activities on areas of the state and/or population groups that have low breastfeeding rates. Work with physicians who are located in these parts of the state and/or provide care for groups with the lowest breastfeeding rates.	Y	Y	Y	Cost effective way of developing efficacious strategies t improve BF rates Lack of resources ? AA BF campaign
• Work with Medicaid physicians to ensure they encourage their patients to breastfeed.	N	N	Y	Should do the same for all physicians. Not Specifically Lack of opportunity
• Provide funding and resources for promotion, support and operation of North Texas Mother's Milk Bank and the Austin Milk Bank and support establishment of others in south and west parts of the state.	N	N	Maybe	Would need to review need, effectiveness. Idea hasn't really come up
• Increase enforcement by police officers and the courts.	N	N	N	Not our call Legislative effort (may happen in 79th Leg.)

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Have WIC projects coordinate with postpartum units to collaborate on breastfeeding education.	N	N	Maybe	May help to ensure consistency of info. Not from the state Need clarification on –ed To new moms? Maybe happening at local level
• Access to breast lactation consultants for assistance, guidance, and encouragement.	Y	N	Y	May help to ensure quality & consistency of info. WIC May help quality & consistency of info.
• Education that seeks to establish additional breastfeeding friendly hospital and other work sites.	Y	Y	Y	Helps to promote a "breastfeeding culture" (Title V and WIC) Helps to promote a "breastfeeding culture"
• Promote prenatal BF education, including in WIC (4 times)	Y	Y	Y	Moms need the info WIC Access to moms
• Increase access to childbirth education for poor women.	Partially	Y	Y	Useful info moms may not otherwise get.
• Promote preconception BF education	N	N	Y	Helps to promote a "breastfeeding culture" Minimal access to women
• Promote postpartum BF education	Y	Y	Y	Critical to have info available WIC and Title V Critical to success
• If supplemental bottles are sent home from the hospital, mothers should be carefully educated in how to use supplementation and still breastfeed successfully.	DK	NA	Y	Make sure it's incorporated in WIC's training to hospital staff. Some hospitals may be doing this.
• Public Awareness/Media campaign to promote benefits of bf (3 times)	Y	Y	N	Support federal campaign Federal Means of getting info out
• Initiate in-hospital campaign to provide educational videos/training on breastfeeding benefits as a medical requirement to every mother delivering in hospitals statewide.	N	N	Y	May be an effective means of educating moms. Hasn't come up
• Collaborate with WIC to educate fathers as to the benefits of breastfeeding for their children and partners.	Y	Y	Y	Fathers play a major role. WIC

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Provide lactation consultation during the third trimester of pregnancy.	N	N	M	The CDC designates professional support as an evidence- based intervention. Infrastructure is not in place.
• Lactation consultant visit should be part of the mothers experience after she gives birth.	N	N	Y	The CDC designates professional support as an evidence- based intervention. Infrastructure is not in place.
12. Percentage of newborns who have been screened for hearing before hospital discharge				
• Initiate in-hospital campaign to provide newborn screenings for hearing as a medical requirement to every mother delivering in hospitals statewide.	Yes	Yes		Mandate is to offer the hearing screening, but the parent may refuse.
• Make hearing screening part of the routine newborn checkup before discharge from the hospital and the regular monthly check-ups	Yes	Yes		Already is
• Educate parents in prenatal clinics and childbirth classes about early hearing screening for newborns	Yes	Yes		Communities have the responsibility of doing this but we provide brochures and information
• Implement universal newborn hearing screening testing at all birthing facilities statewide.	Yes	Yes		Is a law—some small facilities in rural counties are exempt
• Educate mothers to have their children's hearing tested annually through sixth grade.	Yes	Yes		The law mandates screening in school for vision and hearing during K, 1, 3, 5, 7, 9th grades
• Get an audiologic evaluation at first signs of cold or sore throat	No		No	Not up to us…this is a parental decision.
• Follow-up connection to services is time-sensitive and essential. Implementation of the web-based system for community providers, including ECI will hopefully occur in FYO5	Yes	Yes		ECI got HRSA grant and will come online in 2005
• Provide Training and equipment for hospitals lacking	No		Yes	This was done in the past, we provided an one time grant to exempt facilities during 2000, but funding now a problem in being able to offer it again
• Require stricter hospital mandates.	Yes	Yes		Texas has the strictest in the nation. We certify NBHS programs and it is a rigorous process

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Public Health access to non-proprietary screening registries and data to ensure that those newborns who are released without screening prior to leaving the hospital.	No		Maybe	Medical confidentiality would be an issue. DSHS does administer case management (letters and phone calls) to families.

Analysis of Stakeholder Input on National Performance Measure Activities

National Performance Measure • Activities suggested by stakeholders	Status of Activity			Comments
	Currently Done	Continue	If not doing now, do in future?	
NPM 1 - Percent of newborns screened and confirmed with conditions mandated by their state-sponsored NBSP who received appropriate follow-up as defined by their state				
• Provide on-location regional training to personnel handling newborn screens in order to decrease # of unsatisfactory samples (making it necessary to re-test) & intervene quickly with infants at risk for death, mental retardation, or emergency care	Yes	Yes		We are providing TA to providers who need assistance through request or repeat unsatisfactory results.
• Have medical staff (RN) do home visits to do screenings and education as necessary.	No	Maybe		Would be a useful means to capture more infants not previously screened.
• Add FASD to screens	No		No	While increased screening and Surveillance would be useful, FASD is not screened using a blood test/ different methodology.
• Exempt newborns from any taxing authority access restrictions	No		No	Not in our power to do.
• Change the State requirement for the second newborn lab screen to 3-5 days post discharge in order to meet new JCAHO standards for sentinel events on Kernicterus.	No		No	Best to have between first 36 hours. However because infants are in hospital and we have early discharge many are done within 24 hours due to captive audience. The second screen needs to be done after the 10 day milk challenge, so 3-5 days wouldn't really provide enough time. Thus the second screen can be done with pedi visit. Also, JCAHO standards have not been implemented.
• Continue to support efforts currently in place.	Yes	Yes		
• Data integration with TEHDI may improve data quality	No		No	Not feasible due to the fact that the methodology is different for the testing. NBS mailed to lab and hearing screening done at hospital by hospital. Currently there are 4 different data systems for each newborn.

Note: NPMs 2-6 related to CSHCN were not analyzed through this process

Analysis of Stakeholder Input on National Performance Measure Activities

National Performance Measure • Activities suggested by stakeholders	Status of Activity			Comments
	Currently Done	Continue	If not doing now, do in future?	
7. Percent of 19-35 months olds who have received full schedule of age-appropriate immunizations against MMR, Polio, Diphtheria, Tetanus, Pertussis, HIB and Hep B				
• Reinstate age-paced parenting/developmental information mail outs for parents of young children (Take Time for Kids/Texas Tots/Building Blocks).	Partial	Yes		A great source of timely information sent to moms who typically need to be reminded. Currently we are distributing the Healthy Start/Grow Smart Magazines in a bulk manner to parents of children who are enrolled in Medicaid at 3 mos.
• Continue to work with and educate child care providers about the importance of immunizations and how to educate parents on the topic. Increase the number of childcare providers participating in IMMTrac.	Yes	Yes		This is being done through the Healthy Child Care Texas Partnership
• Enforce mandatory immunization reporting from private providers to public health authorities	No		No	Not feasible, would be nice, but can't make private physicians do it unless legislatively mandated
• Promote parent education about importance of keeping documentation	Yes	Yes		Needs to be emphasized, but once Immtrac is fully operational, expanded, and providers use it regularly there will be less of a need for paper documentation
• Multimedia campaign	Yes	Yes		Continue and/or reinstate Shots across Tx
• Convenient immunization clinic hours	Yes	Yes		Needs to be expanded based on funding and staffing
• Re-open some of the health clinics closed down due to budget cuts.	No		Maybe	Depends on budget
• Offer free education classes on immunizations	Yes	Yes		Being done throughout the regions
• Mobile neighborhood immunization clinic to severely-underserved remote areas	No		No	Challenge to maintain records. Care Van, different communities can do this on their own
• Varicella vaccination needs to be included in vaccinations listed	Yes	Yes		Already listed
• WCCHD monitors all childcare facilities and provides education along with audits to increase compliance with shots.	Yes	Yes		

Analysis of Stakeholder Input on National Performance Measure Activities

National Performance Measure • Activities suggested by stakeholders	Status of Activity			Comments
	Currently Done	Continue	If not doing now, do in future?	
• Partner with EMS and safety seat inspection to increase awareness and identify needs of each child attending inspections.	No		Yes	It would be wise to have these groups partner with the Immunization workgroup
• Standardization of immunizations data tracking system	Yes	Yes		Purpose of ImmTrac
• Provide on-going immunization education programs and education to schools, day care, faith-based organizations, and the general community.	Yes	Yes		Continue
• Provide intervention strategies to LHDs for neighborhoods identified as having high rates of under immunized children.	Yes	Yes		More could be done
• Implement Shots across America/ similar project to increase overall number of families reached in the rural areas of community.	No		Maybe	Shots across Texas was a immunization marketing campaign that consisted in a working coalition in every county…it indeed in mid 90's due to lack of funding
• Address issues of medical understaffing to provide increased availability of immunizations/providers in the community	Yes	Maybe		Budgetary Constraints
• Increase immunizations at public health fairs/clinics	Yes	Yes		Continue efforts
• Have home visits set up with client and do immunizations if necessary and/or provide transportation	Partial	Maybe	Maybe	Texas Health Steps provides transportation for their program, but an issue regarding staffing would arise from home visits. Currently if a home visit is made by a caseworker, then the family is provided with education.
• Providers need to be adequately reimbursed so they are not losing money every time they give a shot	Yes	Yes		Legislative issue
• Health care advocates need to work with moms and make sure that infants come in for immunizations	Yes	Yes		Increase efforts

Analysis of Stakeholder Input on National Performance Measure Activities

National Performance Measure • Activities suggested by stakeholders	Status of Activity			Comments
	Currently Done	Continue	If not doing now, do in future?	
• Implement the immtrac immunization registry in order to be better able to track immunizations, make immtrac system easier to use	Yes	Yes		Being worked on
• Partner with TMA on the BE Wise-Immunize campaign to better this statistic and achieve goal.	Yes	Yes		Best practice already in works
• Ensure funding for low cost immunizations	Yes	Yes		Continue dependant on budget
• Reduction of bureaucratic and administrative concerns for providers concerning distribution and administration of vaccines.	Partial	Maybe	Maybe	On-going issue…Streamline TVFC. Currently Federal Reimbursement for national program is $10,000 of free vaccine per provider, but paper work is tedious. Many have issues sustaining program because Providers see red-tape as too much effort for cost.
• Partner with private businesses to offer incentives to families whose children (19-35 months) are fully immunized	Yes	Yes		Corporate partnerships are difficult to obtain, however it is a new task being undertaken and we are currently partnering with a few corporations such as Hallmark and Schliterban.
• Continue with TVFC participation.	Yes	Yes		Will Continue
• Cooperative vaccine purchasing ability through the state for all providers using North Carolina as potential model.	No		Yes	Texas uses 3rd party purchasing, universal vaccine purchasing is not done in Texas…legislative issue
• Vaccination programs in WIC settings	Yes	Yes		WIC is already an important partner

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
13. Percent of children without health insurance				
• Explore the models of states who have shown an increase in children with insurance.	YES	YES		
• Approximately 6,000 children in Webb County are still without health insurance. The Health Department will reach out to families by attending health fairs, PTC meetings, and CHIP application drive in Dec. 04	YES	YES		
• Include dental, vision and mental health benefits on CHIP and other programs, decrease barriers to participation in state-insurance programs	Partial	Yes		Add mental health component to Title V & Healthsteps Barriers need to be addressed by HHSC
• Unconscionable that almost 1 in 4 children has no health insurance! This area needs more media attention!	NO		YES	Media Campaign/ can not provide biased media campaign
• Provide a mechanism at public schools to enroll children and families into Medicaid or CHIP	YES	YES		Coordinate with school health program

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Increase Medicaid and CHIP Outreach in State of Texas, and provide families with more insurance options that can fit their budget.	Partial	YES		We do provide outreach but we have no control over insurance options
• Re-instate CHIPS/similar project at statewide level, provide insurance/Medicaid application to • Mothers at every infant delivery and educate physicians/pediatricians on eligibility requirements to encourage new applications.			YES	Medicaid information should be provided at delivery
• Explore success in other states	YES	YES		
• Target administration and education of how costly ER treatment is			YES	Provide education to communities/alternative to ER for primary care
• Disseminate information in communities and children's service providers about eligibility for Medicaid, Chip and accessing local hospital district services. Improve/expand the areas of health insurance coverage's for children by the government.	YES	YES		Expanding coverage is an HHSC & Legislative function

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Encourage and educate parents bringing children in for immunizations and other DSHS services about options for obtaining health care coverage for their children. Assist with the application process as needed	YES	YES		
• HTCs can provide access to clinical studies for children whose families have no other means of obtaining factor concentrate, which hemophiliacs must have to prevent life-threatening bleeding episodes.	Many of these suggestions are not within the current control of the Title V program. If conditions change, Title V will make every attempt to integrate this stakeholder input			
• Educate the public about sources of revenue for health services and the taxation system				
• Advocate for legislation changes				
• Build low cost health insurance program for low to moderate income working families				
• Provide 'true' integrated eligilbility. Increase the financial guidelines. Implement income based premiums				
• Utilize waiver to allow CHIP funds to purchase employer sponsored insurance for children				

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Approximately 6,000 children in Webb County are sill without health insurance. The Health Department will reach out to families by attending heath fairs, PTC meetings, and CHIP application drive in Dec 04				Many of these suggestions are not within the current control of the Title V program. If conditions change, Title V will make every attempt to integrate this stakeholder input
• Approximately 14,000 uninsured in our country; we have 21.88% in our country presently (1999)				
• Legislative advocacy to increase children's insurance / □Medicaid and CHIP				
• Allow more money for CHIP program to cover more children.				
• Reinstate the 1 on 1 CBO's assistance with new applicant enrollment and to restore the benefits and coverage initially provided by the CHIP program Including behavioral health, Dental, vision, and mechanical Devices.				
• Reinstate medically needy buy-in for Medicaid as an entitlement for children from 0-18				

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• I am sure this number is WRONG. There are many many children and young adults without healthcare in Texas.				Many of these suggestions are not within the current control of the Title V program. If conditions change, Title V will make every attempt to integrate this stakeholder input
• This figure should be 0% for the first 2-3 years. Medicaid and CHIPS must be expanded to accommodate this target.				
• Implement stronger incentives for states to enroll all eligible children in health insurance programs.				
• Put a program in place such as the CHIPS program to have families medical, dental and routine checkup covered at a minimal cost. A periodic schedule must be kept to continue getting medical care at a low cost.				
• Expand CHIP, eliminate barriers to enrollment in CHIP				
• Develop 'Project Access' programs for each county to address children's needs				
• Get information on how form Dallas County Medical Society				

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Continue work with legislature to repeal CHIP cuts, increase access				
• Improve the Medicaid & CHIP application process and don't require renewal so often.				
• Enhance CHIP funding and covered services.				
• Increased public awareness of the effects of this issue on the total community.				
• Continue CSHCH and use more liberal income eligibility possible.				
• Keep non-diagnosis specific eligibility criteria,				
• Increase CHIP funding.				
• Expand CHIP services to all children in need				
• Increase CHIP funding and the number of health care providers				
• Pursue easier access to CHIP with an emphasis on culturally sensitive materials and education.				
• Increase coverage period from 6 months to one year and simplify the reapplication process				

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• The Health Department can only measure the clients they serve, which the % is higher for the uninsured (approx. 80%).				
14. Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program				
• Reinstate age-paced parenting/developmental information mail outs for parents of young children • (Take Time for Kids/Texas Tots/Building Blocks)	YES	YES		Healthy start grow smart sent by THS
• Develop community based educational programs and deliver training to promotora/community outreach programs to reach minority & low-income families regarding the importance of a medical home, well child exams, importance of Medicaid coverage, and services covered by Medicaid.	YES			

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Eliminate barriers by having more providers in high need areas	YES	YES		Attempting through FQHC
• Improved education and training of all healthcare staff, including Community Health Workers	YES	YES		Title V Infrastructure building activities
• Increased outreach efforts through community health workers	YES	YES		Pop-based activity
• Increase awareness among Medicaid enrolled patients concerning knowledge and services of program.	YES	YES		
• Re-instate CHIPS/similar project at statewide level, provide insurance/Medicaid application to mothers at every infant delivery	NO		MAYBE	Another means of targeting a captive audience
• Increase access to the system by decreasing the number of applications 'lost', approval letters never • Sent out, and by not making people start all over because of the State's errors.	YES	YES		

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Screen for coverage.	YES	YES		
• Increase promotoras model	YES	YES		
• More outreach to the community to provide information about available Medicaid free services for • children.	YES	YES		Title V pop-based outreach activity
• Improve eligibility processes in public schools	YES	YES		Partner with school health
• Support school based clinic programs	YES	YES		Partner with school health
• Don't require a medical home- allow patients to go to any doctor accepting medicaid	NO		NO	Not a best practice
• Improve accessibility of medical services.	YES	YES		Title V infrastructure activity
• Make sure that individuals about to age out of EPSDT have gotten their eye exams, eyeglasses, hearing exam, hearing aids, etc. before they turn 21.	YES	YES		Reminder notices would be beneficial

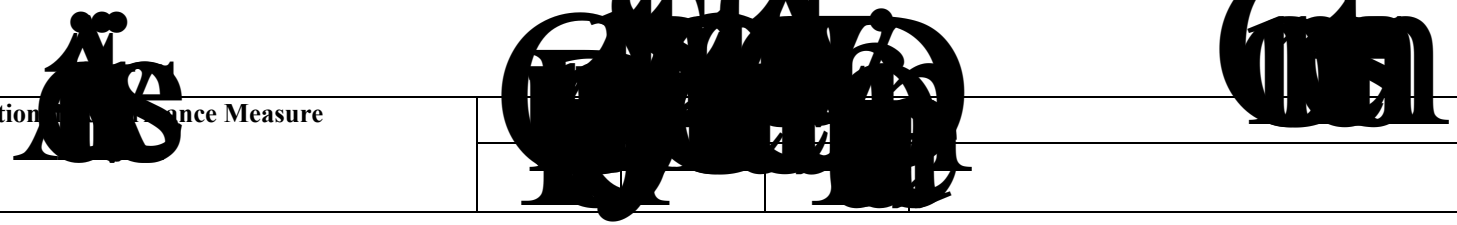
National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Formation of community based coalitions stressing public education with local public health departments participating in if not taking the lead in the community discussions.	YES	YES		Title V outreach
• Make physicals mandatory for school participation, not just immunizations	Many of these suggestions are not within the current control of the Title V program. If conditions change, Title V will make every attempt to integrate this stakeholder input			
• Increase provider base that accepts Medicaid, perhaps provide incentive such as reduced liability premiums.				
• Increase provider base with financial enrollment percentages				
• See #4! Also, reimburse healthcare providers adequately.				
• Create an informing flier to be distributed to children in Medicaid 1915 (c) waiver programs.				

National Performance Measure • Activities	Status of Activity			Comments
	Currently Done	Continue	Do in future	
• Coordinate program to automatically apply Medicaid-eligible children for Medicaid to act as co-insurance				Many of these suggestions are not within the current control of the Title V program. If conditions change, Title V will make every attempt to integrate this stakeholder input
• Home Visits (Guide to Community Preventive Services) (www. thecommunityguide.org)				
• The % of Medicaid clients served in the Health Department are minimal (approx. 15%).				
• Offering incentives to providers who offer extended hours				
• Educate physician pediatricians on eligibility requirements to encourage new applications				
• Increase medical benefits to Medicaid-eligible children.				

Nation[illegible]nce Measure •				
15. The percent of very low birth we[illegible]fants among all live bi[illegible]				
• Assure that all mothers have access to quality PNC/health care				
• Advocate for legislation to create a FIMR				
• Measures to reduce poverty including a living wage so mothers are not forced to work until the very last minute and can feed themselves properly				
• Increase access to existing substance abuse programs				
• Co-location and service coordination				
• Educate private physicians on programs such as WIC that will complement their services				
• Develop educational materials and multi-media messages regarding preconception and interconception counseling				
• Making it a priority for providers to educate about risky behaviors				
• Comprehensive substance abuse prevention program that includes risks of substance use, especially tobacco, on infants. Same, for young women and pgt. Women. Same, including sex practices when under the influence. +2				

Nation[illegible]nce Measure			
• [illegible]			

• Promote adequate pre-pregnancy weight to teens and young women as well as adequate weight gain during pregnancy. (2 times)			
• Improve the health status of reproductive-age women through a campaign to increase physical activity, decrease obesity, reduce tobacco use, reduce stress and increase consistent contraceptive use.			
• Promote community-level abstinence programs (or in schools) to decrease the teen pregnancy rate; Provide multiple models (abstinence +, parenting models, religious and school based models) that are culturally sensitive and include a strong evaluation component			
• Ad campaign targeting women AND health care providers on the importance of early PNC. (2 times)			
• Early screening, identification and education/intervention for client populations at risk for VLBW and LBW babies.			
• Partner with other agencies, ie: MOD, to capitalize on media education, community education, and abstinence.			
• Identify who and where the greatest risks are, adolescents, etc. (2 times)			
• Offering transportation (with educational TV/radio during the ride)			
• Motivational interviewing for substance abuse issues.			



Nation[illegible]nce Measure		
•		

16. The rate (per 100,000) of suicide deaths among youths aged 15 through 19				
• Increase funding for better mental health services that covers counseling and screening	No		No	
• Support services which provide access to early intervention for schools and communities	No		Yes	
• Support after-school programs	No		No	
• Continue efforts in Denton ISD regarding Teen Media fest	No		No	
• Continue abstinence programs	Yes	Yes	Yes	There are currently Abstinence Education Contractors in all 11 PHR
• Educate community, teens and schools to identify teens at risk of suicide, local resources and the importance of appropriate intervention an referral	Yes	Yes	Yes	Administered Regionally on local level
• Integrate suicide prevention programs into middle and high school curriculums		Yes	Yes	Administered on local level
• Provide training for teachers in school on the signs of depression and other mental illness	Yes/No	Yes	Yes	Regionally, targeting areas with the highest incidence
• Hotline staffed by youth and non-judgmental counselors who offer immediate interventions as required	No		No	
• Public awareness education campaign about mental health issues to reduce the stigma and encourage utilization	Yes	Yes	Yes	Texas Mental Health Association
• Conduct epidemiologically based social research which effectively identifies core issues of suicide	No		Yes	
• Development and implementation of a state plan based on state specific research	Yes	Yes	Yes	Administered statewide through grassroots effort

National [illegible] Measure				
•				

17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries				
• Institute national standard for ultrasound evaluation in pregnancy (www.aium.org)				
• Assure that all mothers have access to quality PNC/health care				
• Need more centers with special facilities, especially in rural areas (2 times)				
• Eliminate barriers to accessing such facilities especially to rural communities				
• Have designated hospital and other resources list that are available to the patient for the patient to choose from and have a system in place to follow up on patients.				
• Co-location, cross-training, service integration				
• Provide funding for follow-up clinics for low and very low birth weight children in order to prevent complications of low birth-weight				
• Development of statewide FIMR Boards which can provide information for study of infant deaths that are apparently the result of prematurity and very low birth weight				
• Data not available to Health Department				
• Develop educational materials and multi-media messages regarding preconception and interconception counseling				

National [illegible] Measure				
•				
• Making it a priority for providers to educate patients				
• Improved outreach through community health workers				
• Improved training/education of community health educators and the public				
• Provide increased awareness on appropriate PNC (2 times)				
• Identify high-risk women				
• Comprehensive substance abuse prevention program that includes risks of substance use, especially tobacco, on infants. Same, for young women and pgt. Women. Same, including sex practices when under the influence. (2 times)				
• Education/outreach to the community, making them aware of Free Medicaid and Title V services for women of childbearing age.				
• Intensify media campaigns on causes and preventions. (2 times)				
• Communicate the message of risk factors more effectively to providers and families				

Nation[illegible]nce Measure				
• [illegible]				
• Offering transportation with educational TV/radio during the ride.	[illegible]	[illegible]	[illegible]	[illegible]
• Having an infrastructure to help families in rural areas with transportation to urban areas. (2 times)	[illegible]	[illegible]	[illegible]	[illegible]
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester Chan	[illegible]	[illegible]	[illegible]	[illegible]
• Provide funding for community-based educational programs directed to minority and low-income WCBA regarding the importance of early PNC.	[illegible]	[illegible]	[illegible]	[illegible]
• Assure that all mothers, including the uninsured, have access to quality prenatal care. (2 times)	[illegible]	[illegible]	[illegible]	[illegible]
• Address issues of medical understaffing to provide increased availability of PNC appts in community.	[illegible]	[illegible]	[illegible]	[illegible]
• Prenatal care must be a county priority, encouraged by the state.	[illegible]	[illegible]	[illegible]	[illegible]
• Increase availability of local low risk prenatal care providers in local communities, including school-based clinics. (2 times)	[illegible]	[illegible]	[illegible]	[illegible]
• Provide funding for prenatal care to immigrant populations.	[illegible]	[illegible]	[illegible]	[illegible]
• State to increase more funds at the local level for indigent prenatal care.	[illegible]	[illegible]	[illegible]	[illegible]

National [illegible] Measure				
•				
• Change data reporting procedures to prevent self-report.				
• Offer incentives each prenatal visit, (items the mom will need when the NB is born) with a promise of a large NB item when the child is delivered, such as a baby bed, walker stroller car seat etc.				
• This is what I was talking about when I said that pregnant patients are doing what they should to fill out their applications but that the Medicaid office takes so long to process. These patients should be on a fast track.				
• Coordinate Medicaid eligibility with pregnancy test sites.				
• Increased availability in rural areas - funding to enroll clients, staffing, and contractors.				
• Work with communities and local resources to reduce barriers (health care beliefs, transportation, no local providers or hospitals due to lack of insurance, etc) to accessing early prenatal care particularly for teens.				
• Affordable insurance for those that don't qualify for Medicaid.				
• Supporting a social marketing campaign about risk factors				

National Performance Measure				
•				

• Address teen pregnancy and at-risk mothers through education (2 times)				
• Culturally sensitive individual, community-based and statewide education regarding the importance and effectiveness of early prenatal care.				
• Community outreach at WIC or day cares to help mothers realize importance of early prenatal care.				
• Improved outreach through Community Health Workers.				
• Educate expectant fathers as to the importance for women to receive prenatal care.				
• Ad/Media campaign targeting women AND healthcare providers on the importance of early prenatal care. (3 times)				
• Consumer education regarding the availability of services for non-insured pregnant women.				
• Education and promotion of state programs.				
• HTCs can provide genetic counseling and support for women with a family history of bleeding disorders. (Hemophilia is a hereditary, life-long disease.)				

National [illegible]nce Measure •				
• Increase financial support to Medicaid-paid transportation assistance to increase access to healthcare to those women living in rural areas. (2 times)				
• Work with communities and local resources to reduce barriers (health care beliefs, transportation, no local providers or hospitals due to lack of insurance, etc) to accessing early prenatal care particularly for [illegible]				
[illegible]				

Needs Assessment

Attachment E

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

EDUARDO J. SANCHEZ, M.D., M.P.H.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us

April 29, 2005

Dear Maternal and Child Health Stakeholder:

This is a follow-up to the correspondence dated November 1, 2004, in which the Texas Department of State Health Services Title V Program sought your input in identifying maternal and child health needs, issues, and areas for improvement. First, I would like to thank you for your participation in the first round of the Title V five-year needs assessment effort. Your input has been valuable, diverse, succinct, and encompasses many aspects of the service delivery and systems development needed for the Title V population. At the same time, the input has been overwhelming and it is almost impossible to address every issue and area that require improvement based on the program's capacity and resources at hand.

Title V staff from the Women's and Infants Area and Children's and Adolescents Area analyzed the stakeholder input and established linkages whenever possible with those health status and health systems capacity indicators data that are currently most critical to the Title V population. This analysis generated a list of critical needs by type of population in Attachments A-1 & A-2. Please note that some health status indicators (e.g., immunizations, teen pregnancy, etc.) do not show as critical needs in Attachments A-1 and A-2 since they are already represented among required national performance measures (Attachment B is provided as reference) by the federal Maternal and Child Health Bureau (MCHB).

For this second round, we are seeking your assistance in prioritizing the critical needs appearing in Attachments A-1 and A-2 by selecting the top three critical needs for each population type. This prioritization step is needed since we are limited to submitting to MCHB no more than 10 priority needs, including those pertaining to children with special health care needs. The next steps are to 1) tabulate your selections in order to find out the final priority needs, 2) translate each priority need into a state performance measure, and 3) develop activities to support priority needs/state performance measures. The activities may possibly be taken from your input received in the first round. Once the Title V Block Grant Application is completed, it will be posted on the Title V website. You will receive a notice of the new application and its availability electronically or in hard copy.

Please send your completed Attachments A-1 and A-2 in the enclosed return envelope no later than **Wednesday, May 18, 2005**. You may also fax results to **512/458-7358, ATTN: Title V Input.** If you have questions or need additional information, please call me at (512) 458-7321 or email your questions to TitleVinput@dshs.state.tx.us. My sincere thanks to you for your strong interest and efforts in helping improve the health of Texans.

Sincerely,

Fouad Berrahou, Ph.D.
State Title V Director
Title V and Health Resources Development Office
Division of Family and Community Health Services

Attachment A-1
Title V Program Five-Year Needs Assessment
Population Group: Women (over 22 years) and Infants (0-11 months)

Instructions: Critical needs are listed below for women and infants. **Select the top three (3) needs by clicking on the box in the column next to that need**. Please submit responses no later than **Friday, May 13, 2005.** Suggested criteria to consider in selecting the top three needs include but are not limited to 1) high incidence/prevalence, 2) increasing trends, 3) severity of consequences, and 4) amenability to an intervention proven effective by research.

Note: Please select only 3 needs on Attachment A-1. If more than 3 are selected, the first 3 needs selected will be counted.

Check only 3 boxes	CRITICAL NEEDS	RATIONALE	Healthy People 2010 or other U.S. data	Texas data
☐	Reduce domestic violence	Domestic violence (DV) increases during pregnancy. Homicide is the leading cause of mortality for women in the immediate pre- and post-delivery time period. DV increases stress, can lead to premature births or miscarriage, may result in loss of a caregiver (in case of death), and may lead to a repetitive cycle of abuse in families.	HP 2010 target 3.3/1000 assaults from current or former partner	2003 Family Violence Victim rates: All women – 13.23/1000 Ages 20-29- 33.43/1000
☐	Reduce rate of adult suicides	Risk of suicide is significantly greater for women 35-44, possibly attributed to depression from hormonal fluctuations and perimenopausal / menopausal symptoms. Suicide may result in family stress, anxiety and depression; loss of income; and potential loss of caregiver. Rates are highest for Whites.	U.S. 2002 9.5/1000	2002 All - 9.6/1000 Whites– 14.4/1000 Age 35-44 - 15.7/1000
☐	Decrease infant mortality for African Americans	There is an increasing trend for all races, with a startling health disparity for African Americans.	U.S. 2002 7/1000 live births	2002 All - 6.4/1000 AA – 13.5/1000
☐	Decrease low birth weights for African Americans	A clear disparity exists for African Americans. Low birth weight has been linked to infant mortality, failure to thrive, increased susceptibility to infections, obesity, diabetes and heart disease.	HP 2010 goal 5%	2002 All – 7.7/1000 AA – 12.7/1000
☐	Decrease preterm birth rate for African Americans	Prematurity has been linked to infant mortality, failure to thrive, increased susceptibility to infections, long-term disability, cerebral palsy, mental retardation, learning problems, chronic lung disease and vision and hearing problems.	U.S. 2002 12.1%	2002 All - 10.3% AA – 14.1%
☐	Improve onset/adequacy of prenatal care for adolescents	Women who receive early and adequate prenatal care have improved birth outcomes and are better prepared for breastfeeding and parenting. Less than half of Texas females aged 10-14 receive early and adequate prenatal care.	HP 2010 goal 90%	2002 All - 72.3% 10-14 - 46.3% 15-19 - 60.1%
☐	Increase breastfeeding for White (W), African American (AA), and adolescent mothers	Breastfeeding is the healthiest way to feed infants, providing short and long-term benefits for the infant, mother, family and society. Breastfeeding has been linked to better maternal and infant health, higher intelligence, better school performance, lower incidence of obesity and lower costs.	HP 2010 goal 75% on hospital discharge 50% at 6 months	2004 Women/Infant/ Children data 0 – 6 mo All - 40.5% W - 30.5 AA - 26% 10-14 - 15.9% 15-19 - 29.6%
☐	Decrease adult obesity	Obesity rates are rising faster in Texas than national levels. Obesity is linked to decreased physical activity and multiple adverse health conditions including joint pain, stress, depression, diabetes, cardiovascular disease, and some forms of cancer. For pregnant women, there may be increased incidence of neural tube defects and possible links to obesity, diabetes and cardiovascular disease as the infant ages.	U.S. 1998 –18.3% 2002 – 21.4%	Texas 1998 - 21.1% 2002 – 24.5%
☐	Increase awareness of perinatal and postpartum depression	The impact of postpartum depression on children is as great or greater than the impact of a parent who abuses alcohol. Studies link perinatal depression to low birth weight and other poor birth outcomes.	Current U.S. estimate for postpartum depression 10 – 20%	2003 Adults over age 18 with major depression 3%
☐	Decrease fetal/maternal exposure to smoking, alcohol and other drugs	Although in many cases, the full extent or duration of the impact is not known, substance use adversely affects maternal and child health outcomes. Fetal Alcohol Spectrum Disorder is an example of a preventable birth defect with long-term complications for the child and family.	No data available at this time	2002 Of women who reported use of substance use during pregnancy, tobacco use- 6.2% alcohol – 1%

Continue to next page, Attachment A-2 (Children and Adolescents)

Attachment A-2
Title V Program Five-Year Needs Assessment
Population Group: Children and Adolescents (1-21 years)

Instructions: Critical needs are listed below for children and adolescents. **Select the top three (3) needs by clicking on the box in the column next to that need**. Please submit responses no later than **Friday, May 13, 2005.** Suggested criteria to consider in selecting the top three needs include but are not limited to 1) high incidence/prevalence, 2) increasing trends, 3) severity of consequences, and 4) amenability to an intervention proven effective by research.

Note: Please select only 3 needs on Attachment A-2. If more than 3 are selected, the first 3 needs selected will be counted.

Check only 3 boxes	CRITICAL NEEDS	RATIONALE	Healthy People 2010 or other U.S. data	Texas data
☐	Decrease incidence of obesity	Obesity is linked to decreased physical activity, diabetes, cardiovascular disease, joint pain and mobility problems. The highest incidence in Texas children ages 1-4 is among Hispanics.	U.S. 1999 – 10.8% 2001 – 10.5% 2003 – 13.5%	1999 - 10.5% 2001 - 14.2% 2003 - 13.9%
☐	Increase unintentional injury prevention and safety	Unintentional injuries can result in traumatic brain injury and lifelong debilitating consequences for the child, family and society. They are a leading cause of death for Texas children 1-4 years of age.	U.S. 2002 Child death rate, ages 1-14 21.2%	2002 Child death rate, ages 1-14 23.3%
☐	Increase access to dental care	Lack of access to dental care results in untreated dental caries and other oral health problems. Possible impacts may include chronic mouth pain, disrupted eating patterns, and loss of school and work time for families. Dental caries is 5-7 times more common than reported respiratory disease among 5-17 year olds.	U.S. 2004 Children living in poverty have 4X more dental caries	2003 Age 1-14 Texas Health Steps eligible – 47% received oral health screens
☐	Decrease the incidence of child abuse and neglect	Child abuse and neglect impact the mental health and productivity of victims and families, can result in injury, unintended pregnancy or STDs and can be repeated in succeeding generations. The highest rates occur in African Americans (AA).	U.S. 2001 Victims 0-17 12.4/1000	2001 Victims 0-17 All - 7.2/1000 <1year– 9.3/1000 AA – 13.8/1000
☐	Increase healthcare infrastructure	Early and periodic screening results in fewer adverse health outcomes. In 2004, 52% of Texas counties were designated as Health Professional Shortage Areas. Less than 60% of children eligible for Texas Health Steps were screened in 2003.	U.S. 2004 Children w/o health insurance 12%	2004 Children w/o health insurance 22%
☐	Increase mental health screening and service access	Untreated, mental disorders result in loss of school and work time, loss of productivity, possible suicide or victim crime, and increased family stress. Prevalence of mental disorders in juvenile justice facilities ranges from 50-75%.	HP 1010 report Age 9-17 – 20% have mental disorders	2002 Age <18 – 150,481 with serious mental disorders
☐	Increase vision and hearing screening	Lack of vision and hearing screens may lead to developmental delays in children, impacting academic success and future productivity.	HP 2010 target 90%	2004 – 95% tested for hearing on hospital discharge
☐	Increase health screening for domestic violence, sexual abuse, and substance abuse	Undetected, these issues lead to lost school and work time, unintended pregnancies and STDs, increased family stress and repeat cycles of abuse. Detection of the issues is identified as a best practice to prevent teen pregnancy when used as an integrated approach.	U.S. 2002 Homicides, age 1-14 1.4/1000	2002 Homicides, age 1-14 1.7/1000 AA - 4.4/1000
☐	Improve the quality of care delivered though daycare facilities	Almost 1 million infants and children are in licensed daycare and many more are cared for in unlicensed facilities. Although not a recognized or integrated system, poor quality daycare can adversely affect the health and safety of the children and families.	No data available at this time	2004 Age <5 - 903,094 enrolled in 22,888 licensed daycare facilities
☐	Substance abuse prevention	Substance use/abuse is directly linked to motor vehicle crashes, adversely impacts the ability to make sound decisions and can lead to cardiovascular, liver, gastrointestinal and mental health problems.	U.S. 2001 high school students – 47.1% used alcohol in lat 30 days	2001 high school students – 48.6% used alcohol in lat 30 days
☐	Reduce repeat teen pregnancy	Teen pregnancy has a higher incidence of pre-term birth and low birth weight than for older women. Repeat pregnancies usually result in loss of school and work time and increased stress for the mother and family.	No data available at this time	2002 age 13-17 - 17.1% are repeat pregnancies
☐	Increase resiliency and developmental assets among adolescents	Youth developmental asset programs can lead to increased sexual responsibility (a Healthy People 2010 leading indicator), impacting the rates of sexually transmitted infections, teen pregnancy and other adolescent issues. Multi-faceted programs that teach life skills attempt to increase self worth and ease the transition to productive adulthood.	U.S. 2001 45.6% of high school students have had sexual intercourse	2001 50.4% of high school students have had sexual intercourse
			HP 2010 target for chlamydia – 3% for age 15-24 in STD/family planning clinics	2002 Age 15-24 – 74% of reported cases of chlamydia
			2001 high school dropout rate – 9%	2001 high school dropout rate – 12%

When Attachments A-1 and A-2 are completed, please save and submit as an attached file to TitleVInput@dshs.state.tx.us no later than Friday, May 13, 2005.

Attachment B
Title V National Performance Measures

1. Percent of newborns screened and confirmed with conditions mandated by their state-sponsored NBSP who received appropriate follow-up as defined by their state
2. Percent of Children with Special Health Care Needs (0-18 yrs) whose families partner in decision making at all levels and are satisfied with services they receive
3. Percent of Children with Special Health Care Needs age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home
4. Percent of Children with Special Health Care Needs age 0-18 whose families have adequate private or public insurance to pay for the services they need
5. 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
6. Percentage of youth with Special Health Care Needs who received the services necessary to make transition to all aspects of adult life
7. Percent of 19-35 months olds who have received full schedule of age-appropriate immunizations against MMR, Polio, Diphtheria, Tetanus, Pertussis, HIB and Hep B
8. Rate of birth (per 1,000) for teenagers aged 15 through 17 years
9. Percent of 3rd grade children who have received protective sealants on at least one permanent molar tooth
10. Rate of deaths to children aged 14 yrs and younger caused by motor vehicle crashes per 100,000 children
11. Percentage of mothers who breastfeed their infants at hospital discharge
12. Percentage of newborns who have been screened for hearing before hospital discharge
13. Percent of children without health insurance
14. Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program
15. The percent of very low birth weight infants among all live births
16. The rate (per 100,000) of suicide deaths among youths aged 15 through 19
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Needs Assessment

Attachment F

Results of stakeholder prioritization
Attachment 1 – Women & infants

Critical need	# of Respondents	%
Improve Prenatal Care Adolescents	50	62.5
Reduce Domestic Violence	41	51.3
Decrease Adult Obesity	38	47.5
Decrease Fetal Exposure Smoking Alcohol Drugs	35	43.8
Increase Breastfeeding W AA Adolescents	16	20.0
Increase Awareness Postpartum Depression	14	17.5
Decrease Low Birth Weight AA	11	13.8
Decrease Infant Mortality AA	10	2.5
Decrease Prematurity AA	3	3.8
Reduce Adult Suicide	2	2.5

Total Number of Respondants: 80

Results of stakeholder prioritization
Attachment 2 – Children & adolescents

Critical Need	# of Respondents	%
Obesity	37	46.3
Healthcare Infrastructure	28	35.0
Access Dental Care	27	33.8
Reduce Repeat Teen Pregnancy	23	28.8
Mental Health Screening	23	28.8
Child Abuse Neglect	22	27.5
Developmental Assets Adolescents	21	26.3
DV, Sexual, and Substance Abuse Screens	17	21.3
Substance Abuse Prevention	9	11.3
Daycare Facilities	9	11.3
Unintentional Injuries	8	10.0
Vision Hearing Screening	5	6.3

Total Number of Respondants: 80

Needs Assessment
Attachment G

ASSESSMENT OF EXISTING SCHOOL-BASED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

Texas Education Agency
Division of Interagency Coordination
1701 North Congress Avenue
Austin, Texas 78701-1494
512- 463-9283
www.tea.state.tx.us

January 2005

ASSESSMENT OF EXISTING SCHOOL-BASED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

EXECUTIVE SUMMARY

Research shows that prevention, early identification, and treatment of mental health and substance abuse problems are critical to children's successful participation in school, family, and community. In response to growing concerns that existing programs are inadequate to meet the needs of Texas children, Senate Bill 491 mandated an assessment of school-based mental health and substance abuse programs.

In March 2004, the Texas Education Agency surveyed all public school campuses in Texas; 3,847 of about 8,000 public school campuses (48%) responded. Along with background on the state of mental health and substance abuse programs for children, this report presents survey findings, insights from a meeting of 30 stakeholder organizations, and recommendations for future direction.

SUMMARY FINDINGS

- At all grade levels, schools cited counseling as their most successful approach to identifying and addressing students' mental health and substance abuse problems.

- Drug and alcohol abuse were the top two challenges identified by high schools.

- School counselors spend most of their work time on tasks other than mental health and/or substance abuse counseling, especially in high school.

- Schools cited a variety of prevention and intervention programs, but no statewide standard for mental health and substance abuse programs exists.

- Most schools provide students and families with resource information and referrals to a wide range of mental health and substance abuse programs. No mechanism exists to track whether referrals result in care.

- Almost three-fourths of school campuses had been trained in the Texas Behavior Support Initiative, designed to provide positive behavior support for students, especially those with disabilities.

- Schools generally rated themselves as successful or fairly successful in providing resource information and referrals for students with mental health or substance abuse problems, and as moderately or fairly successful in identifying such

students and providing school-based services for them. The current research does not include an independent assessment of the quality of school-based programs and services.

- Stakeholders identified components of successful school-based mental health and substance abuse programs, including adequate funding, program evaluations, the presence of mental health and substance abuse professionals on staff at all grade levels, training for families and school staff, and linkages to community-based services. They cited about a dozen model school-based programs. (see Appendix B). Their recommendations ranged from better coordination and integration of services to improved teacher training and more counseling time devoted to substance abuse.

SUMMARY RECOMMENDATIONS

- Charge local School Health Advisory Councils with exploring the coordination of mental health and substance abuse needs and services for their districts.

- Encourage local school boards to adopt policies on positive behavior support to improve campus environment.

- Teach positive behavior support in preservice programs and alternative certification programs as a tool for classroom management.

- Increase the amount of time high school counselors devote to substance abuse prevention and substance abuse counseling.

- Maximize resources by encouraging child-serving agencies to coordinate services to children.

- All teachers should receive preservice credit hours or continuing education hours for training in early identification of students with mental health and/or substance abuse problems.

- Encourage the expansion of the wrap-around process for children's mental health services.

Needs Assessment

Attachment H

TEXAS YOUTH RISK BEHAVIOR SURVEY

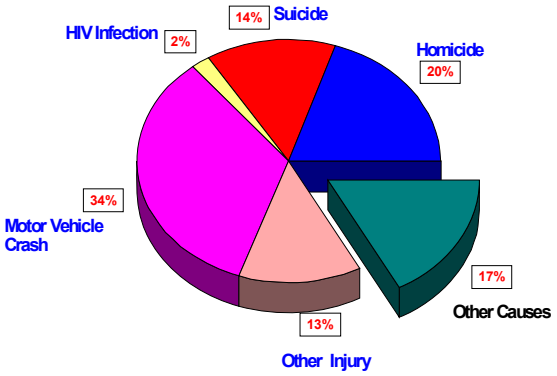
2003 Summary Results

Grades 9-12 Students

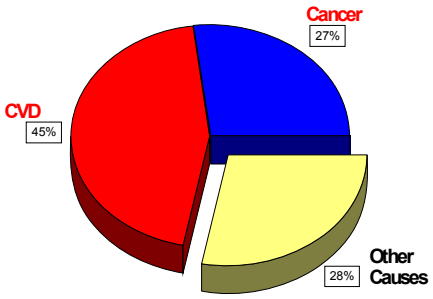
(excluding Houston Independent School District)

These Texas-specific leading causes of death . . .

YOUTH AGES 10-24



ADULTS AGES 25 AND OLDER



… result from these risk behaviors practiced by students in grades 9-12…

Unintentional Injuries and Violence

8%	Rarely or never used safety belts
33%	Rode with a drinking driver during the past month
16%	Carried a weapon during the past month

Tobacco Use

59%	Ever smoked cigarettes
24%	Smoked cigarettes during the past month
8%	Smoked cigarettes on 20 or more days during the past month

31% Were in a physical fight during the past year

11% Attempted suicide during the past year

7% Used smokeless tobacco during the past month

15% Smoked cigars during the past month

Alcohol and Other Drug Use

43% Drank alcohol during the past month

26% Reported episodic heavy drinking during the past month

20% Used marijuana during the past month

12% Ever used cocaine

12% Ever sniffed or inhaled intoxicating substances

Sexual Behaviors

51% Ever had sexual intercourse

16% Ever had four or more sex partners

36% Had sexual intercourse during the past three months

38% Did not use a condom during last sexual intercourse

88% Did not use birth control pills during last sexual intercourse

Dietary Behaviors

16% At risk for becoming overweight

14% Overweight

82% Ate < 5 servings of fruits and vegetables per day during the past 7 days

89% Drank < 3 glasses of milk per day during the past 7 days

Physical Activity

40% Did not participate in vigorous physical activity

80% Did not participate in moderate physical activity

48% Were not enrolled in physical education class

70% Did not attend physical education class daily

36% Did not participate in vigorous physical activity and did not participate in moderate physical activity

2003 Texas Youth Risk Behavior Survey
Summary Findings for Grades 9-12 Students

This report summarizes the results of the 2003 Texas Youth Risk Behavior Survey (YRBS). YRBS data provide a wealth of data for state and local health and education officials to a) implement or modify programs to address the behaviors of young people; b) create awareness of the extent of risk behaviors among young people; c) promote state-level changes that support specific health education curricula and coordinated school health programs; and d) provide evidence-based data to support the need for health education. Data from YRBS also serve as a valuable tool for legislators and other policy makers as they make decisions about health related policies, services, programs, and educational activities. Developed by the Centers for Disease Control and Prevention (CDC) in collaboration with federal, state, and private-sector partners, the Youth Risk Behavior Surveillance System (YRBSS) was designed to focus the nation on behaviors among youth related to the leading causes of mortality and morbidity among both youth and adults and to assess how these risk behaviors change over time.

Efforts to identify health risks to Texas teens and to plan ways to help prevent risky behaviors have been difficult. Historically, the first Texas YRBS was done statewide by the Texas Education Agency (TEA), with the UT School of Public Health in Houston, in the school year 1992-1993 and by the Texas A&M University School of Rural Public Health in March 1998. During spring of 1999, the Texas Department of Health (TDH) conducted a modified school-based YRBS statewide. CDC, however, could not include any of these Texas results in the national data because of inadequate school and student participation. TDH again conducted the survey during the spring of 2001 with the assistance of CDC and was able, for the first time, to achieve the adequate school and student response rate of more than 60 percent. YRBS again was conducted by TDH in 2003 with the assistance of CDC.

The results of 2003 Texas YRBS are representative of all students in grades 9 through 12 in Texas (excluding students enrolled in the Houston Independent School District because of inadequate survey response rate). A total of 4,075 students in 49 public high schools in Texas completed the survey during the spring of 2003. The overall school response rate was 83 percent while the overall student response rate was 80 percent, for an overall response rate of 67 percent.

The 2003 Texas YRBS Summary Findings Report summarizes the responses Texas public high school students gave about health related behaviors. The multiple-choice YRBS questionnaire was developed by CDC and is conducted every two years to produce data representative of students in grades 9 through 12. The survey contained questions relating to priority health risks that result in the most significant causes of death and disability among teens, including:

1. Behaviors that result in unintentional injuries and violence;
2. Tobacco use;
3. Alcohol and other drug use;
4. Sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies;
5. Dietary behaviors; and
6. Physical activity

This report is the first in this 2003 YRBS series of reports summarizing priority health-risk behaviors that result in the most significant causes of death and disability among Texas teens.

METHODS

Sampling

The Texas state YRBS employed a two-stage cluster sample design to produce representative samples of students in grades 9 through 12. The first-stage sampling frame included lists of public high schools containing the appropriate grades. Schools were selected with a probability proportional to the school enrollment size. The list includes a total of 59 eligible schools (including 36 schools selected for the Texas state YRBS and 23 schools located in Dallas). At the second sampling stage, classes were randomly selected from the list of classes obtained from each participating school. All students in the selected classes were eligible to participate in the survey.

The school response rate was 83 percent (49 of 59 sampled schools participated) while the student response rate was 80 percent (4,075 of the 5,087 sampled students completed usable questionnaires). Overall response rate was 67 percent (school response rate times student response rate).

Data Collection

The survey was administered during one class period. Procedures were designed to protect students' privacy by assuring that student participation was anonymous and voluntary. Students completed a self-administered questionnaire in the classroom, recording their responses on an answer sheet. The core questionnaire contained 87 multiple-choice questions. Before the survey was administered, local parental permission procedures were followed.

Weighting

For each student record, a weighting factor was applied to adjust for non-responses at the school and student level and for varying probabilities of selection. The weights were then post-strata adjusted so that the weighted proportion of students in each grade and gender matched Texas student population proportions. SUDAAN was used to compute 95 percent confidence intervals to determine differences among subgroups at the $p<0.05$ level. Differences between prevalence estimates were considered statistically significant if the 95 percent confidence intervals did not overlap.

RESULTS

In this summary report, the overall prevalence (with 95 percent confidence intervals) related to a priority behavior is presented. The Texas 2001 YRBS prevalence data results are also presented for comparison.

FINDINGS RELATED TO BEHAVIORS THAT RESULT IN UNINTENTIONAL INJURIES AND VIOLENCE

SEAT BELT USE

- In 2003, about **7.9 percent** (**95% CI**, 6.6%-9.3%) of Texas students had rarely or never worn seatbelts when riding a car driven by someone else. (**2001**: 10 percent (8.7%-12.2%).

BICYCLE HELMET USE

- In 2003, about 55 % of Texas students had ridden a bicycle during the past 12 months. Of these students, about **92 percent** (90.0%-94.0%) rarely or never wore a bicycle helmet (**2001**: 92 percent (91.3%-93.5%)).

RIDING WITH A DRIVER WHO HAD BEEN DRINKING ALCOHOL

- In 2003, about **32.9 percent** (29.5%-36.3%) of Texas students had ridden $\geq$ 1 times with a driver who had been drinking alcohol during the 30 days preceding the survey (**2001**: 40% (36.5%-42.9%)).

DRIVING AFTER DRINKING ALCOHOL

- In 2003, about **12 percent** (10%-14.2%) of Texas students had driven a car or other vehicles $\geq$ 1 times after drinking alcohol during the 30 days preceding the survey (**2001**: 16% (14.7%-17.8%)).

FINDINGS RELATED TO BEHAVIORS THAT CONTRIBUTE TO VIOLENCE

CARRYING A WEAPON

- In 2003, about **16.4 percent** (14.1%-18.8%) of Texas students reported that they had carried a weapon such as gun, knife or club on ≥ 1 of the 30 days preceding the survey (**2001**: 18% (14.8%-21.1%)).

- In 2003, about **6 percent** (4.0%-7.9%) of Texas students reported that they had carried a gun on ≥ 1 of the 30 days preceding the survey (**2001**: 5% (3.9%-6.6%)).

PHYSICAL FIGHTING

- In 2003, about **31.5 percent** (28.1%-34.8%) of students had been in a physical fight ≥ 1 times during the 12 months preceding the survey (**2001**: 33% (29.7%-35.4%)).

- In 2003, about **3.7 percent** (2.8%-4.5%) of students had been treated by a doctor or nurse for injuries sustained in a physical fight ≥ 1 times during the 12 months preceding the survey (**2001**: 4.0% (3.1%-4.4%)).

DATING VIOLENCE

- In 2003, about **8.5 percent** (7.7%-9.4%) of students reported that they had been hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend ≥ 1 times during the 12 months preceding the survey (**2001**: 10% (7.8%-11.8%))

FORCED SEXUAL INTERCOURSE

- In 2003, about **7.7 percent** (6.2%-9.2%) of students had ever been forced to have sexual intercourse when they did not want to (**2001**: 8% (6.5%-9.8%)).

SCHOOL RELATED VIOLENCE

- In 2003, about **5.2 percent** (4.3%-6.1%) had missed ≥ 1 days of school during the 30 days preceding the survey because they felt unsafe at school or on their way to or from school (**2001**: 7% (6.1%-8.8%)).

- In 2003, about **5.8 percent** (4.3%-7.3%) of students carried a weapon (such as a gun, knife or club) on school property on ≥ 1 of the 30 days preceding the survey (**2001**:7% (5.5%-9.5%)).

- In 2003, about **7.7 percent** (6.3%-9.0%) of students reported that they had been threatened or injured with a weapon on school property ≥ 1 times during the 12 months preceding the survey (**2001**: 9% (7.6%-9.5%)).

- In 2003, about **13.3 percent** (11.3%-15.4%) of students had been in a physical fight on school property ≥ 1 times during the 12 months preceding the survey (**2001**: 13% (11.2%-14.8%)).

- In 2003, about **29.5 percent** (27.2%-31.8%) of students reported that their property, such as their car, clothing, or books had been stolen or damaged on school property during the past 12 months (**new in 2003**).

SADNESS AND SUICIDE IDEATION AND ATTEMPTS

- In 2003, about **31.7 percent** (29.3%-34.1%) of students had felt so sad or hopeless almost every day for ≥ 2 weeks in a row that they stopped doing some usual activities during the past 12 months prior to the survey (**2001**: 29% (26.8%-31.8%)).

- In 2003, about **17.3 percent** (15.6%-19.0%) of students had seriously considered attempting suicide during the past 12 months preceding the survey (**2001**: 18% (16.4%-19.0%).

- In 2003, about **13.4 percent** (12.1%-14.7%) had made a specific plan to attempt suicide during the past 12 months preceding the survey (**2001**: 13% (12.3%-14.5%)).

- In 2003, about **10.6 percent** (8.6%-12.6%) of students attempted suicide ≥ 1 times during the past 12 months preceding the survey (**2001**: 9% (7.9%-10.1%)).

- In 2003, about **3.3 percent** (2.4%-4.1%) of students made a suicide attempt during the 12 months preceding the survey that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (**2001**: 2% (1.7%-2.9%)).

FINDINGS RELATED TO TOBACCO USE

CIGARETTE USE

- In 2003, about **59.4 percent** (56.8%-62.0%) of students had ever tried cigarette smoking, even one or two puffs (lifetime use) (**2001**: 66% (62.5%-69.8%)).

- In 2003, about **24.3 percent** (22.5%-26.1%) of students smoked cigarettes on one or more of the past 30 days (current cigarette use) (**2001**: 28% (26.1%-30.8%)).

- In 2003, about **7.9 percent** (6.4%-9.3%) of the students had smoked cigarettes on 20 or more of the past 30 days (current frequent cigarette use) (**2001**: 10% (8.2%-12.6%)).

- In 2003, of the students who reported current cigarette use, **1.5 percent** (0.8%-2.1%) smoked more than 10 cigarettes on the days they smoked (**2001**: 2% (1.1%-2.6%)).

SMOKELESS TOBACCO USE

- In 2003, about **6.8 percent** (5.1%-8.5%) of students had used chewing tobacco or snuff on one or more of the past 30 days preceding the survey (current smokeless tobacco use) (**2001**: 9% (6.6%-10.9%)).

CIGAR USE

- In 2003, about **14.6 percent** (12.6%-16.6%) of students had smoked cigars, cigarillos, or little cigars on one or more of the 30 days preceding the survey (current cigar use) (**2001**: 16% (13.8%-17.5%)).

CURRENT (ANY) TOBACCO USE

- In 2003, about **28.4 percent** (26%-30.7%) of students had reported current cigarette use, current smokeless tobacco use, or current cigar use on one or more of the 30 days preceding the survey (current any tobacco use) (**2001**: 33% (30.2%-35.1%)).

ACCESS TO CIGARETTES

- In 2003, about **16.6 percent** (12.7%-20.4%) of students less than 18 years of age who were current cigarette smokers purchased their cigarettes in a store or gas station during the 30 days preceding the survey (**2001**: 19% (14.8%-22.4%)).

FINDINGS RELATED TO ALCOHOL AND OTHER DRUG USE

ALCOHOL USE

- In 2003, about **76.9 percent** (74.4%-79.5%) of students had had at least one drink of alcohol on one or more days during their lifetime (lifetime alcohol use) (**2001**: 81% (78.3%-83.0%)).

- In 2003, about **43 percent** (39.2%-46.8%)) of students had had at least one drink of alcohol on one of the 30 days preceding the survey (current alcohol use) (**2001**: 49% (45.4%-51.8%)).

- In 2003, about **25.7 percent** (22.9%-28.5%) of students had had five or more drinks of alcohol on more than one occasion during the 30 days preceding the survey (episodic heavy drinking) (**2001**: 31% (28.7%-33.8%)).

MARIJUANA USE

- In 2003, about **40.9 percent** (37.3%-44.5%) of students had used marijuana during their lifetime (lifetime marijuana use) (**2001**: 41% (36.3%-46.3%)).

- In 2003, about **20.4 percent** (18.9%-22.0%) of students had used marijuana one or more times during the 30 days preceding the survey (current marijuana use) (**2001**: 22% (17.8%-25.7%)).

COCAINE USE

- In 2003, about **12.1 percent** (10.0%-14.1%) of students had used a form of cocaine (powder, crack, or freebase) during their life (lifetime cocaine use) (**2001**: 13% (10.2%-15.8%)).

- In 2003, about **5.5 percent** (4.2%-6.8%) of students had used a form of cocaine one or more times during the 30 days prior to the survey (current cocaine use) (**2001**: 6% (4.9%-7.6%)).

INHALANT USE

- In 2003, about **12.5 percent** (10.4%-14.6%) of students had sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or spray to get high during their lifetime (lifetime inhalant use) (**2001**: 14% (12.4%-15.4%)).

- In 2003, less than **4.2 percent** (2.9%-5.5%) of students had use inhalants one or more times during the 30 days prior to the survey (current inhalant use) (**2001**: 5% (3.8%-5.2%)).

HEROIN USE

- In 2003, about **2.3 percent** (1.6%-3.0%) of students had used heroin during their lifetime (lifetime heroin use) (**2001**: 3% (2.1%-3.8%)).

METHAMPHETAMINE USE

- In 2003, about **8.3 percent** (6.9%-9.7%) of students had used methamphetamines during their lifetime (lifetime metamphetamine use) (**2001**: 8% (7.0%-9.9%)).

ECSTASY USE

- In 2003, about 9.8 percent (8.2%-11.4%) of students had used ecstasy one or more times during their life (lifetime ecstasy use). **(new in 2003**)

STEROID USE

- In 2003, about **5 percent** (3.6%-6.5%) of the students had used illegal steroids (without a doctor's prescription) during their lifetime (lifetime steroid use) (**2001**: 6% (4.7%-6.85%)).

INJECTING DRUG USE

- In 2003, about **1.9 percent** (1.2%-2.7%) of students had injected illegal drugs during their lifetime (lifetime injecting-drug use) (**2001**:2% (1.6%-2.6%)).

AGE OF INITIATION OF RISK BEHAVIORS

CIGARETTE USE

- In 2003, about **16.8 percent** (15.0%-18.6%) of students had smoked a whole cigarette before age 13 (**2001**: 21% (18.4%-24.2%)).

ALCOHOL USE

- In 2003, about **28.2 percent** (26.2%-30.2%) of students had first drunk alcohol (more than a few sips) before age 13 (**2001**: 29% (26.1%-32.6%)).

MARIJUANA USE

- In 2003, about **9.9 percent** (8.2%-11.6%) of students had tried marijuana before age 13 (**2001**: 11% (8.3%-13.8%)).

TOBACCO, ALCOHOL, AND OTHER DRUG USE ON SCHOOL PROPERTY

- In 2003, about **6.2 percent** (4.8%-7.5%) of students had smoked cigarettes on school property on one or more of the past 30 days preceding the survey (**2001**: 7% (5.7%-9.1%)).

- In 2003, about **4.1 percent** (2.8%-5.5%) of students had used smokeless tobacco on school property on one of the past 30 days preceding the survey (**2001**: 5% (4.0%-6.7%)).

- In 2003, about **4.6 percent** (3.5%-5.6%) of students had had at least one drink of alcohol on school property on one of the past 30 days preceding the survey (**2001**: 6% (4.9%-6.9%)).

- In 2003, about **4.8 percent** (4.0%-5.6%) of students had used marijuana on school property one or more times during the past 30 days preceding the survey (**2001**: 5 % (3.6%-7.1%)).

- In 2003, about **27.3 percent** (24.9%-29.8%) of students had been offered, sold, or given an illegal drug on school property during the 12 months prior to the survey (**2001**: 28% (25%-31.3%)).

FINDINGS RELATED TO SEXUAL BEHAVIORS THAT CONTRIBUTE TO UNINTENDED PREGNANCY AND STDs, INCLUDING HIV INFECTION

SEXUAL INTERCOURSE

- In 2003, about **51.3 percent** (47.9%-54.7%) of students had had sexual intercourse during their lifetime (**2001**: 50% (44.9%-55.9%)).

- In 2003, about **6.8 percent** (5.5%-8.1%) of students had initiated sexual intercourse before age 13 years (**2001**: 7% (5.4%-9.7%)).

- In 2003, about **15.6 percent** (14.0%-17.2%) of students had had sexual intercourse with four or more sex partners during their lifetime (**2001**: 16% (12.9%-20.0%)).

- In 2003, about **36.4 percent** (33.1%-39.7%) of students had had sexual intercourse with one or more people during the three months preceding the survey (currently sexually active) (**2001**: 36% (31.4%-41.0%)).

CONDOM USE

- In 2003, among the currently sexually active students, **62.0 percent** (57.5%-66.5%) reported that either they or their partner had used a condom during the last sexual intercourse (**2001**: 55% (50.9%- 59.9%)).

BIRTH CONTROL PILL USE

- In 2003, among the currently sexually active students, **11.9 percent** (10.1%-13.8%) reported that either they or their partner had used birth control pills before last sexual intercourse (**2001**: 11% (8.1%-13.6%)).

ALCOHOL OR DRUG USE AT LAST SEXUAL INTERCOURSE

- In 2003, among the currently sexually active students, **19.1 percent** (16.1%-22.0%) had used alcohol or drugs at last sexual intercourse (**2001**: 27% (23.6%-29.6%)).

PREGNANCY

- In 2003, about **4.6 percent** (3.3%-5.9%) of students had been pregnant or had gotten someone else pregnant (**2001**: 7% (4%-10.8%)).

HIV EDUCATION

- In 2003, about **77.9 percent** (73.4%-82.4%) of students had been taught in school about AIDS or HIV infection (**2001**: 83% (80.1%-85.7%)).

FINDINGS RELATED TO DIETARY BEHAVIORS

OVERWEIGHT

- In 2003, about **16.4 percent** (14.6%-18.1%) of students were at risk for becoming overweight (**2001**: 15% (13.1%-16.5%)).

- In 2003, about **13.9 percent** (11.9%-15.9%) of students were overweight (**2001**: 14% (12.1%-16.2%)).

- In 2003, about **29.4 percent** (27.3%-31.5%) thought they were slightly or very overweight (**2001**: 31% (29.4%-33.1%)).

- In 2003, about **46.5 percent** (44.3%-48.6%) of students were trying to lose weight (**2001**: 47% (45.2%-49.8%)).

CONSUMPTION OF FRUITS AND VEGETABLES

- In 2003, about **17.5 percent** (15.9%-19.2%) of students had eaten five or more servings of fruits and vegetables per day during the past seven days preceding the survey (**2001**: 20% (18.6%-21.2%)).

- In 2003, during the past seven days preceding the survey, **80.2 percent** (**2001**: 81 %) of the students drank 100 percent fruit juices, **82.7 percent** (**2001**:82 percent) ate fruit, **60.5 percent** (**2001**: 62 percent) ate green salad, **66.4 percent** (**2001**:70 percent) ate potatoes, **40 percent** (**2001**: 41 percent) ate carrots, and **79.3 percent** (**2001**:81 percent) ate other vegetables one or more times.

CONSUMPTION OF MILK

- In 2003, overall, **11.1 percent** (9.4%-12.8%) of students drank three or more glasses of milk per day during the past seven days preceding the survey (**2001**: 14% (12.9%-15.7%)).

ATTEMPTED WEIGHT CONTROL

- In 2003, about **60.7 percent** (58.1%-63.2%) of students had exercised to lose weight or to keep from gaining weight during the 30 days preceding the survey (**2001**: 60% (57.2%-62.1%)).

- In 2003, about **41.9 percent** (40.1%-43.6%) of students had eaten less food, fewer calories, or foods low in fat to lose weight or to keep from gaining weight during the past 30 days preceding the survey (**2001**: 43% (40.9%-45.3%)).

- In 2003, about **14 percent** (12.6%-15.4%) of students had gone without eating for 24 hours or more to lose weight or to avoid gaining weight during the past 30 days preceding the survey (**2001**: 14% (13% - 14.9%)).

- In 2003, about **8.7 percent** (7.1%-10.3%) of students had taken diet pills, powders, or liquids without a doctor's advice to lose weight or to avoid gaining weight during the past 30 days preceding the survey (**2001**: 9% (8.6%-10.3%)).

- In 2003, about **5.3 percent** (4.4%-6.1%) of students had vomited or taken laxatives to lose weight or avoid gaining weight during the past 30 days preceding the survey (**2001**: 6% (5.1%-6.5%)).

FINDINGS RELATED TO PHYSICAL ACTIVITY

PHYSICAL ACTIVITY

- In 2003, about **59.9 percent** (57.0%-62.9%) of students had participated in activities that made them sweat and breathe hard for at least 20 minutes on three or more of the 7 days preceding the survey (**sufficient vigorous physical activity**)(**2001**: 62% (59.2%-64.3%)).

- In 2003, about **20.2 percent** (18.6%-21.9%) of students had participated in activities that did not make them sweat or breathe hard for at least 30 minutes on five or more of the past seven days preceding the survey (**sufficient moderate physical activity**) (**2001**: 22% (20.0%-24.0%)).

- In 2003, about **35.7 percent** (33.2%-38.2%) of students had not participated in vigorous activity for at least 20 minutes on three or more of the past seven days preceding the survey and had not participated in moderate physical activity for at least 30 minutes on five or more of the past seven days preceding the survey (**insufficient amount of physical activity**) (**2001**: 34% (31.5%-37.1%)).

- In 2003, about **10.7 percent** (8.9%-12.4%) of students had not participated in either vigorous physical activity for at least 20 minutes or moderate physical activity for at least 30 minutes on any of the seven days preceding the survey (**2001**: 11% (9.3%-12.3%)).

PARTICIPATION IN PHYSICAL EDUCATION CLASS

- In 2003, about **51.9 percent** (46.4%-57.5%) of students were enrolled in a physical education (PE) class (**2001**: 48% (43.5%-52.5%)).

- In 2003, about **29.7 percent** (23.9%-35.5%) of students attended PE class daily (**2001**: 33% (28.0%-37.7%)). Of these students (in 2003), 84.5 percent exercised more than 20 minutes during an average PE class

PARTICIPATION ON SPORTS TEAM

- In 2003, about **54 percent** (51.2%-56.7%) of students had played on one or more sports teams during the 12 months preceding the survey (**2001**: 57% (53.9%-59.6%)).

STRENGTHENING EXERCISES

- In 2003, about **53.4 percent** (49.6%-57.1%) of students had done strengthening exercises on at least three of the seven days preceding the survey (**2001**: 52% (49.1%-54.7%).

WATCHING TELEVISION

- In 2003, about **44.1 percent** (40.8%-47.4%) of students had watched television three or more hours per day during an average school day (**2001**: 44% (40.6%-48.3%)).

OVERALL SUMMARY

The results of 2003 Texas YRBS are representative of all public school students in grades 9 through 12 (excluding students enrolled in the Houston Independent School District). This marks the second consecutive time that overall participation rate in the Texas YRBS exceeded 60 percent.

Results of the 2003 survey showed that too many Texas teens continue to practice behaviors that place them at risk for serious acute and chronic health problems. The following results, however, showed significant decreases in the prevalence of a specific priority behavior when compared with 2001 data:

- The percent of students who rode in a car or other vehicle driven by someone who had been drinking alcohol one or more times during the past 30 days preceding the survey decreased from **40 percent in 2001** to **32.9 percent in 2003**.

- The percent of students who drove a car after they had been drinking alcohol during the past 30 days preceding the survey decreased from **16 percent in 2001** to **12 percent in 2003**.

- Lifetime use of cigarettes decreased from **66 percent in 2001** to **59.4 percent on 2003**.

- The percent of students who had had five or more drinks of alcohol on more than one occasion during the 30 days preceding the survey (episodic heavy drinking) decreased from **31 percent in 2001** to **25.7 percent in 2003**.

- The percent of currently sexually active students who had used alcohol or drugs at last sexual intercourse decreased from **27 percent in 2001** to **19.1 percent in 2003**.