



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

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

The Texas Title V Program operates within the strategic plan framework articulated by Texas State Government, the Texas Health and Human Services Commission (HHSC) and the Texas Department of Health and, as such, is an important component in achieving the Visions, Missions, Philosophies, Goals and Benchmarks of these entities.

Texas' priority goal for health and human services as outlined by the Governor's Office of Budget and Planning is as follows:

To reduce dependence on public assistance through an efficient and effective system that promotes the health, responsibility, and self-sufficiency of individuals and families.

The statewide benchmarks relevant to this goal are consistent with requirements of Title V and Title V national outcome and performance measures. The relevant statewide benchmarks include:

Incidence of vaccine-preventable disease
Infant mortality rate
Teen pregnancy rate
Low birth weight rate
Number of persons enrolled in Medicaid
Incidence of confirmed cases of abuse, neglect, or death of children, the elderly, persons with disabilities, or spouses

The Vision, Mission and Philosophy of the Texas Department of Health further support and strengthen the Texas Title V Program.

TDH Vision Statement

We commit, through personal and organizational excellence, to be an agent of change dedicated to achieving a healthier Texas.

TDH Mission Statement

The mission of the Texas Department of Health is to protect and promote the health of the people of this state. In keeping with this mission, each program or activity

conducted by the Department will strive to obtain the most up-to-date information possible about public health conditions, to direct its human and financial resources toward the areas where improvements in public health are needed, and to make every effort to ensure that the people of Texas receive the vital information and services needed to maintain and improve the health of the public.

At the core of TDH's strategic plan is a newly articulated philosophy created in partnership with internal and external stakeholders, the Board of Health and TDH executive managers. This philosophy sets forth the principles that guide TDH's public health activities and are consistent with Title V. These principles are to:

- C Support community-based solutions
- C Ensure that public health efforts lead to improved health outcomes
- C Make prevention the priority of public health efforts
- C Carry out the state's leadership role

The success of the State's and the Title V Program's efforts to craft and implement a strategic direction depends on an ability to predict, understand, and strategize around factors that impact the health and well-being of women and children in the context of their communities. The next section provides an overview of some of these important characteristics for Texas.

Texas Demographic, Economic, and Social Trends

According to data from the U.S. Census Bureau, Texas has grown in population from 14.2 million in 1980 to an estimated 20 million in 1999, an increase of nearly 41 percent. Increased births and net migration are equally dominant factors driving Texas population growth. Projections indicate continued growth of the racial/ethnic diversity of the state. Forecasts predict that by the year 2030 the Texas population will reach approximately 34 million. By 2030, it is estimated that 46 percent of the population will be Hispanic, 36 percent Non-Hispanic White, ten percent African American, and eight percent other (primarily Asian).

Current economic indicators show that the Texas economy remains healthy and will continue its robust growth over the next five years. The per capita income in Texas for the third quarter of 1999 was \$26,060 compared with \$25,105 for 1998 and \$23,850 in 1997. Personal income is expected to grow at an approximately of 5.8 percent between 2000 and 2005.

Unemployment in Texas is at an all time low. The seasonally adjusted unemployment rate in Texas for March 2000 was 4.6 percent. Yet, while the state unemployment rate is very low, some regions of Texas are still experiencing double-digit rates of unemployment. The Texas Workforce Commission March 2000 estimates show that unemployment rates ranged from a low of 2.1 percent in the greater Austin area to a high of 27 percent in some counties along the Texas-Mexico border.

Although economic indicators overall suggest a healthy economy for Texas, poverty rates indicate that segments of the population still struggle with scarce financial resources and the

increased health risks associated with a lower economic standard of living. According to the U.S. Census Bureau, 16.5 percent of Texans lived in poverty in 1999. This is an increase over 1998 when the Texas poverty rate was estimated to be 15.9 percent.

There remains a significant poverty rate by age, region and ethnicity in Texas. The 17 years of age and under age group remains proportionately the largest group in poverty. In 1999, 24 percent of those age 17 years and under live at or below the poverty level. Hispanics and African-Americans continue to represent a disproportionate number of those Texans living under poverty conditions. The latest data indicates that a higher percentage of African-Americans (25.7 percent) and Hispanics (27.7 percent) than whites (8.1 percent) are living at or below poverty.

Among the 50 states and the District of Columbia, Texas has the highest percentage of the population without health insurance and ranks 49th in the percentage of children without health insurance. Of the approximately 4.8 million Texans without health insurance, it is estimated that 1.4 million are below the age of 18. Minority populations make up the largest percent of Texas' uninsured with 52.7 percent Hispanic, 15.2 percent African-American, and 32.1 percent White or Other.

Texas covers approximately 263,000 square miles and has 254 counties. There are 121 counties designated as Health Professional Shortage Areas (HPSA) for primary medical care and 71 counties designated as HPSA for dental care. Of the 254 counties in Texas, 176 whole counties and 47 partial counties are designated as Medically Underserved Areas (MUA). Approximately 15 percent of the population live in rural areas and 85 percent of the population live in urban areas. Further, 5 percent of the population live in 50 percent of the counties. Texas has 65 local health departments (down from 70 in 1990) designated as "participating" and 80 local health departments designated as "non-participating". Of the 254 counties in Texas, approximately 150 counties have no local public health presence.

Additional indicators of the health and social status of women and children and communities in Texas are articulated and analyzed in the Needs Assessment section of this report. But it is evident that there are many opportunities for Texas to improve the health status of women and children.

Major State Policy Issues Related to Maternal and Child Health

The State has several priority areas related to maternal and child health and the Title V Program plays an important role in developing and implementing these legislative and agency policy initiatives.

Title XXI: Children's Health Insurance Program (CHIP)

With the passage of Title XXI, Texas began planning and implementation of a state children's health insurance program. Texas has implemented CHIP in two phases. Phase 1 became effective July 1, 1998 as a Title XIX Medicaid expansion to extend eligibility to children ages 15

to 19 at or below 100 percent federal poverty level (FPL). With Phase 1, the Texas Medicaid Program covers children from birth to one year of age up to 185 percent FPL, ages one through 5 up to 133 percent FPL, and ages 6 through 18 up to 100 percent FPL.

CHIP Phase II is a state-designated program targeted to children ages 0 through 18 years of age at or below 200 percent FPL who are not otherwise eligible for Medicaid. Texas also covers legal immigrant children who are ineligible for CHIP under federal law because of their immigration status. Because these children are not eligible for the federal CHIP match, their coverage will be financed solely with state revenue.

There are several features of CHIP worth noting.

- C Eligibility is based on income, family size, insurance status, citizenship/immigrant status, and residency. There is no assets test.
- C Eligibility is continuous for a 12-month period.
- C Cost-sharing will apply to most eligible families, including annual enrollment fees and co-pays for families between 100 percent and 150 percent FPL; monthly premiums and co-pays for families above 150 percent FPL.
- C Children must be uninsured for a minimum of 90 days (good cause exceptions will be considered).
- C Continuous enrollment will be available during the first year of operation. Thereafter, specific open-enrollment periods may be used.

The state is conducting an aggressive, multi-faceted outreach campaign over a two-year period. *TexCare Partnership* is the name of the “generic” children’s health insurance campaign intended to target all families with uninsured children. This outreach effort includes a statewide advertising campaign that promotes a message targeted to all families with uninsured children. The outreach effort is largely community-based with an emphasis on cultural competency.

A generic application for children’s health insurance provides eligibility determination for CHIP and an eligibility screening and referral process to Medicaid. Families may apply over the phone, by mail, or in consultation with a community-based organization or health care provider.

In addition to CHIP and Medicaid, the state is also involved in a public-private partnership with the Texas Healthy Kids Corporation (THKC). This is a legislatively-created, non-profit entity charged with providing affordable health insurance to uninsured children. THKC is authorized to solicit private sector funds for premium assistance. Children not deemed eligible for CHIP or Medicaid are referred to THKC. Families who choose to participate in THKC will either purchase coverage at full cost or at reduced cost if they qualify for premium assistance and funds are available.

Statewide enrollment of children for CHIP began May 1, 2000 with the application and enrollment call center operational on April 3, 2000. As of June 12, 2000, application, eligibility determination, and enrollment activity for CHIP, Medicaid, and THKC are listed in the table

below.

CHIP Application, Eligibility, and Enrollment Activity		
Applications		
Total Applications Contacts Via Phone or Mail (families, not children)		116,890
Eligibility		
Total Potential Medicaid Eligible Children	24,576	
Total CHIP Children	29,941	
Total THKC Referrals	4,894	
Total Children With a Tentative Eligibility Determination		59,411
Enrollment		
Actual Number of Children Receiving Services	17,032	
Estimated Number of Enrollees Not Yet Receiving Services	6,265	
Estimated Number of Children Enrolled in CHIP		23,297

It is anticipated that enrollment in the program will steadily increase over an 18-month period, with full enrollment in CHIP estimated to be 428,000 children. In addition, it is estimated that 60,000 children will enroll in the Medicaid program as a result of the CHIP screening and referral process. There are no estimates at this time regarding the likely number of children who will enroll in the THKC program as a result of the generic application process.

Medicaid Managed Care

Texas continues to roll out Medicaid managed care. As of March 1, 2000, there are over 500,000 participants in managed care with approximately 63.5 percent in health maintenance organizations and 36.5 percent in the primary care case management model. Texas currently provides services under the Medicaid managed care program in the following service areas:

- C Travis (9 county area)
- C Bexar (7 county area)
- C Tarrant (6 county area)
- C Lubbock (9 county area)
- C Harris (6 county area)
- C Southeast Region (5 county area)
- C Dallas (7 county area)
- C El Paso (3 county area)

The 76th Texas Legislature imposed a moratorium on further expansion of Medicaid Managed Care pending a full evaluation and report to the 77th Texas Legislature in January, 2001. The purpose of the evaluation is to review issues such as access, cost-savings and administrative complexity. This legislatively-mandated evaluation is in addition to ongoing quality evaluations required by the Waiver.

Other Legislative action of particular note was the requirement that the HHSC develop and

implement an expedited process for determining eligibility and enrolling pregnant women and newborns in Medicaid managed care plans. The legislation requires HHSC to ensure immediate access to prenatal services and newborn care. HHSC established goals that 80 to 100 percent of all newborns will be certified and enrolled in managed care in the first month of birth, and 80 to 100 percent of pregnant women will be certified, enrolled and obtain a doctor's appointment within 30 days of application. Texas received approval from HCFA for the expedited enrollment process on March 1, 2000 and implemented the process for expedited enrollment of pregnant women on April 1, 2000 and plans to have the process for expedited enrollment of newborns effective July 1, 2000. Providing access to health care for pregnancy women and infants as early as possible is expected to result in improved pregnancy and infant outcomes.

Welfare Reform

The overall impact of welfare reform has not yet been well documented or analyzed at the state level. However, according the *Texas Kids Count 2000*, many families who need assistance and are entitled to public assistance program, are not receiving services. *Texas Kids Count 2000* reports a decline in participation of many social services such as Medicaid, Food Stamps and TANF. While some of this may be attributable to improvements in the Texas economy, factors related to eligibility and enrollment procedures, burdensome administrative requirements, and fear of problems with immigration status may also be contributing to a decline. Some statistics indicate important considerations for women and children.

- C Despite the fact that no changes were made to Medicaid eligibility in Texas as a result of welfare reform (and, in fact, Medicaid eligibility was expanded with CHIP Phase I), Medicaid enrollment dropped 20 percent from 1995 to 1999.
- C The number of children in Texas who left TANF Medicaid from 1996 to 1999 (270,689) was matched by a growth of 49,203 in the income-related children's Medicaid groups (18 percent of the decline in TANF).
- C Between 1996 and 1999, the percent of poor children in Texas receiving Food Stamps dropped from 80 percent to 60 percent.
- C Texas has seen a 47 percent decline in its TANF caseload between 1994 and 1998, a decline that is not fully explained by an improvement in the poverty rate.
- C Census data shows that 18 percent of Texas children live in a family with one or more non-citizen parents (27 percent of children at or below 200 percent FPL). Anecdotal evidence suggests that many families avoid using benefits for which they are eligible because they fear enrollment would create immigration problems for a family member.

As a result of mandates from the 76th Texas Legislature, HHSC is working with the other health and human service agencies and the Texas Workforce Commission to provide outreach and informing activities, to streamline administrative processes, and to increase access for families entitled to health and human service programs. Title V program staff are participating in workgroup activities lead by HHSC to provide training to outreach and eligibility workers on immigration issues related to "public charge".

Since Title V has been excluded from being designated a means-tested program, Texas Title V policy has not changed. Title V continues to serve women, infants, children, adolescents and CSHCN who are Texas residents, regardless of immigrant or citizenship status.

Tobacco Settlement

In 1998, Texas negotiated a \$17.3 billion tobacco lawsuit settlement agreement that provides funding for a variety of health and child health initiatives. As part of the settlement agreement, counties, cities and hospital districts received \$2.3 billion to help recoup some of the costs of providing health care to indigent patients with tobacco-related illnesses. Distributions will occur annually using the earnings from a permanent trust fund and are based on unreimbursed health care expenditures as defined in the settlement. TDH is responsible for processing expenditure statements submitted by the local entities and certifying to the State Comptroller the pro rata share each entity is to receive from the annual distribution.

The 76th Texas Legislature created several permanent endowments from tobacco settlement funds related to health that could impact the Title V populations. Earnings from these endowments are to be used to fund specific activities by TDH over the FY2000 – 2001 biennium. The *Permanent Fund for Tobacco Education and Enforcement* was endowed for \$200 million with earnings to be used for programs to reduce tobacco use in the state, including prevention education initiatives geared toward youth. Title V School Health Program staff are active participants in planning tobacco initiatives for youth.

The Permanent Fund for Children and Public Health is endowed for \$100 million with earnings to be used to provide grants to local communities to address specific health priorities. The intent of the grants is to improve health outcomes at the community level, using innovations that can be replicated in many places in Texas, and, to the maximum extent possible, bring about improvements in health status that are demonstrable or measurable. Forty-three applications from across the state were approved for funding beginning in FY2001.

In addition to creating permanent endowments, tobacco settlement funds were directly appropriated to children's health programs for the FY2000 – 2001 biennium as follows:

- C \$9 million was appropriated to reduce the waiting list for children in the Medically Dependent Children Program, a 1915 (c) Medicaid waiver program for children who are medically complex.
- C \$2.8 million was appropriated to establish the Universal Newborn Hearing Screening Program.
- C \$179.6 million was appropriated to provide state matching funds for the Title XXI CHIP plan.

TDH Priority Initiatives Related to Maternal and Child Health

Under the leadership of the Texas Legislature, the Board of Health and TDH executive management, TDH has defined several key policy and systems initiatives for women, children

and youth, and children with special health care needs. These policy and systems initiatives are intended to provide a platform designed to lead to improvement in health outcomes for women and children, including children with special health care needs. The Associateship for Community Health and Resources Development, which is the Title V administrative entity for TDH, has been identified as the lead for coordinating development and implementation of these key policy and systems initiatives. The initiatives include:

- C Youth Health Initiative
- C Women's Health Initiative
- C Children with Special Health Care Needs Initiative
- C Service Delivery Integration

Youth Health Initiative

The Youth Health Initiative is an initiative identified and defined by the Board of Health and is considered to be a high-priority for TDH. The purpose of the Youth Health Initiative is to improve health outcomes among children and adolescents by increasing resiliency through youth development. Youth development focuses on the building of strengths that are critical to children's and adolescents' ability to thrive and to resist risk-related behaviors that have a negative impact on health. Findings of the widely disseminated "National Longitudinal Study on Adolescent Health" show consistent evidence that perceived caring and connectedness to others is important in understanding the health of young people today. Youth development mobilizes all residents of the community to play a role in collectively nurturing youth. Programs that adopt and promote the policy of nurturing all children (not just those 'at risk') will enhance traditional public health practices by positively influencing the health decisions that children and youth make. To date, a workgroup of internal TDH staff has been assembled and a leader has been identified in order to develop, implement and evaluate youth development activities throughout TDH. Opportunities for collaboration between TDH and community based organizations statewide are under development. Next year, communities in Texas will be identified and supported in initiating community-driven programs related to youth development.

As a subset of the Youth Health Initiative, the School Health Initiative will coordinate the various TDH health promotion, health education and health screening programs for youth into a unified, comprehensive, holistic approach. The schools will serve as one of the important vehicles for access to the community in implementing aspects of this model.

Women's Health Initiative

During the 76th Texas Legislative session, a proposal was introduced to fund a women's health program at TDH. The proposal, the Texas Campaign for Women, called for additional funding for comprehensive women's health services and was supported by a wide variety of organizations, agencies, and associations. Although the proposal never left the legislative committee, the Texas Campaign for Women increased awareness of the need to provide and coordinate health programs for women across the life span.

Following the legislative session, TDH initiated an evaluation of the organizational structure of the women's health programs across the agency. Under the direction of the Associate Commissioner for Community Health and Resources Development, a reorganization plan was drafted which included development of a new Bureau of Women's Health. Creating a new Bureau served to highlight women's health issues and to realign women's health programs across TDH under one administrative entity. In addition to a new Bureau of Women's Health, an Office of Women's Health was established under the Bureau and is managed by the Bureau's Medical Consultant. A process has been established to bring together TDH programs and a wide variety of external stakeholders and community partners to develop a statewide women's health agenda. This group should provide the vision and strategic direction for further development of systems of health care for women. Under the leadership of Janet Lawson, M.D., the workgroup has met several times and has developed a vision, mission and set of guiding principles for a women's health agenda. The workgroup has begun preliminary work on a women's health report card for the state.

A major initiative under the new Bureau of Women's Health is the implementation of regional perinatal health systems to improve perinatal health outcomes for women and infants. The regional perinatal health system will be supported by a plan to implement the Pregnancy Risk Assessment and Monitoring System (PRAMS) statewide. These two initiatives will become powerful tools and vehicles for directing improvements in systems of care and, subsequently, health outcomes at the community level.

CSHCN Initiative

Senate Bill 374, passed by the 76th session of the Texas Legislature, directs TDH to create a new children with special health care needs program. The intent of this legislation is to move the existing Chronically Ill and Disabled Children's Program from a categorical, diagnosis restricted program to a program more comparable to CHIP or Medicaid. The CSHCN Program will cover additional children who are otherwise uninsured or under-insured. The program will also provide family support services not covered by medicaid, CHIP or traditional insurance programs.

The legislation had the following key provisions:

- C Changes the program name from Chronically Ill and Disabled Children's Services (CIDC) program to the Children with Special Health Care Needs Program;
- C Requires TDH to provide CSHCN with access to a health benefit plan similar in scope to CHIP, with implementation by July 1, 2001;
- C Redefines CSHCN from specific diagnoses to a broader functional definition for a person younger than 21 who has a chronic physical or developmental condition or a person of any age with cystic fibrosis;
- C Removes the asset test from the financial eligibility criteria but retains the medical spenddown provision;
- C Allows waiting lists to ensure the Program is administered within appropriated levels;
- C Provides for development of family support services.

Under the direction of Doctor Susan Penfield, Title V CSHCN Director, the CSHCN Division has undertaken the redevelopment initiative to complete the mandated changes. This major system redesign requires involvement of consumers, providers, advocates, and other stakeholders in the eventual rulemaking process that must be completed to implement a new program by the required date of July 1, 2001. Division staff anticipate completion of the rules process by February of 2001.

Service Delivery Integration (SDI)

Texas has a twelve-year cycle for the sunset review process in which the sunset review committee makes recommendations to the Legislature regarding whether an agency's functions are still needed and if legislative changes are needed. From 1997 to 1999, TDH underwent the sunset review process. The recommendations resulting from the sunset review were legislated in House Bill 2085 of the 76th Texas Legislature. A key requirement in HB 2085 directed TDH to integrate the functions of its different health care delivery programs to the maximum extent possible, including integrating functions of both Medicaid and non-Medicaid health care delivery programs.

Functions identified for integration include health care policy development, health care service delivery (medical home), and administration of contracts (including uniform procurement, contracting terms, billing, reporting, and monitoring). The programs identified as "in scope" for Phase 1 include the Maternal and Child Health programs (including the CSHCN program), Family Planning (Titles X, XX, XIX), Primary Health Care Program, WIC, and Medicaid. The Associateship for Community Health and Resources Development was identified as the lead for operationalizing the service delivery integration (SDI) directive.

The legislation requires initiation of a SDI pilot by September 1, 2000. An interim progress report regarding planning and implementation must be submitted to the Legislature no later than September 1, 2000. The pilot is effective September 1, 2000, through August 31, 2001. The legislation allows TDH to continue successful elements of the pilot after the August 31, 2001, as part of the general duty to integrate health care delivery programs. A final report to the Legislature is due September 1, 2001, including an evaluation of the SDI project and a report of the successes and problem areas foreseen in statewide implementation and expansion of SDI.

The Associate Commissioner of Community Health and Resources Development appointed members to the SDI Core Team to lead the SDI initiative. The Core Team members represent TDH programs and the Regions. The responsibilities of the Core Team include leading the SDI initiative through the design, development, implementation, and evaluation of the pilot and expansion of service delivery integration.

The complexity of the SDI initiative demanded the enlistment of program experts to accomplish development activities. Adjunct Teams were formed to provide technical expertise in the areas of policy development, clinical standards, contract administration, and information technology.

- C SDI Adjunct Policy Development Team. The policy team created health care administrative policies integrating the various program requirements into the policies.
- C SDI Adjunct Clinical Standards Team. The clinical standards team developed integrated, uniform and simplified clinic operational and medical standards.
- C SDI Adjunct Contract Administration Team. The contract administration team assisted the Core Team in developing an integrated, single contract. The team will continue to work on an integrated contract administration system.
- C Information Technology Adjunct Team. The IT team was charged with supporting the SDI initiative through the development and implementation of an automated system. The IT Team created an automation system for eligibility determination and a billing and reporting system for the pilot.

In order to get information that would be useful in planning for the expansion of SDI, it was necessary to consider the effects of SDI in both the rural and urban areas of Texas in choosing pilot sites. The following five SDI pilot sites met pilot selection criteria and agreed to participate:

- C Smith County Health Department, Tyler, Texas
- C Denton County Health Department, Denton, Texas
- C South Plains Community Action Association, Lubbock, Texas
- C Fayette Memorial Hospital, Bastrop, Texas
- C Tarrant County Health Department, Dallas, Texas

The SDI project consists of two phases. Phase 1 of the SDI initiative includes: planning, integration, conducting the pilot, and evaluation. Phase 2 of SDI includes plans for statewide expansion and plans for inclusion of additional TDH programs/services.

The SDI initiative requires a high level of involvement from internal and external stakeholders. During the planning stage of Phase 1, contractors participated in a survey regarding their experiences with TDH programs, administration, contract management, and billing and reporting. The survey supports the need for integration of policy, contracts, and billing and reporting. Continued and consistent communication with the contractors/providers in the pilot sites is paramount in the success of SDI. The Core Team will work hand-in-hand with the pilot sites to encourage success and support the pilot areas. The contractors/providers will participate in interviews and focus groups throughout and at the conclusion of the pilot. Information will be obtained from individual participants in SDI and from the pilot site communities.

Internal stakeholders have been major players in SDI serving as Adjunct Team members and technical experts and they will continue to be involved throughout the SDI project. Updates regarding the pilot will be provided on a regular basis to TDH staff. Feedback from the internal stakeholders will be necessary for evaluating the pilot and planning for expansion of SDI.

It is felt that these four important initiatives - Youth Health Initiative, Women's Health Initiative,

Children with Special Health Care Needs Redevelopment, and Service Delivery Integration - will provide a framework for constructing a more integrated, comprehensive system of care for women, infants, children, adolescents and children with special health care needs. While the focus of the Associateship has historically been to manage a set of categorical programs, these initiatives provide the basis for focusing on the needs of the populations we serve in the context of their communities rather than programmatic needs.

1.5 The State Title V Agency
1.5.1 State Agency Capacity
1.5.1.1 Organizational Structure

State Government

TDH is the state agency responsible for administration of the Title V Program and is one of 13 state health and human services agencies under the umbrella of the Texas Health and Human Services Commission (HHSC). Other agencies under the authority of HHSC include:

- C Texas Rehabilitation Commission
- C Texas Department of Mental Health and Mental Retardation
- C Texas Department of Human Services
- C Texas Department of Protective and Regulatory Services
- C Texas Commission for the Blind
- C Texas Department of Aging
- C Texas Commission on Alcohol and Drug Abuse
- C Texas Commission for the Deaf and Hard of Hearing
- C Interagency Council on Early Childhood Intervention Services
- C Texas Juvenile Probation Commission
- C Health Care Information Council
- C Children's Trust Fund of Texas

House Bill 2641 of the 76th Texas Legislature enhanced HHSC's operational responsibility for managing and directing the health and human service agencies through greater supervision of each agency director. As a result, the HHSC Commissioner is authorized to employ the Commissioner of Health with the Board of Health's concurrence and Governor's approval and to supervise and direct the activities of the Commissioner of Health. Further, the Board of Health is required to enter into a Memorandum of Understanding with the HHSC Commissioner.

HHSC has responsibility for coordinating development and submission of joint agency strategic plans and a consolidated budget. HHSC is involved in policy development for all TDH programs and, as such, reviews all proposed rules of the health and human service agencies. HHSC, as the State Medicaid Agency and CHIP Agency, is the official policy making body for the portions of those programs administered by TDH. The increased authority and responsibility of HHSC has been instrumental in increasing coordination for planning and implementation and has helped reduce duplication and maximize resources across the health and human service agencies.

TDH Organization

Beginning in the Fall, 1998 and through the Spring, 1999 TDH undertook a department-wide reorganization to more effectively align the agency with the TDH strategic directions. This resulted in the creation of four Deputyships: 1) Community Health and Prevention; 2) Public Health Sciences and Quality; 3) Health Care Financing; and 4) Administration. The Title V

Program is located in the Deputyship for Community Health and Prevention under the leadership of Mr. John Evans.

The Deputyship of Community Health and Prevention is comprised of two Associateships: 1) Associateship for Community Dynamics and Prevention; and the 2) Associateship for Community Health and Resources Development. In addition, the Offices of Minority Health and Cultural Competency, Border Health, and Language Services are located under the management of the Deputyship. The Title V Program is located in the Associateship for Community Health and Resources Development. Doctor Jack Baum was named Acting Associate Commissioner in August, 1998 and formally appointed Associate Commissioner in May, 1999.

In the Fall, 1999 each Associateship was charged with developing a plan for further aligning their organizational structure in support of TDH and the Deputyship strategic directions. This has resulted in several key organizational changes. The following section will describe the organization of the Associateship for Community Health and Resources Development and will note those organizational changes.

Associateship for Community Health and Resources Development

The Associateship is comprised of three Bureaus under the Associate Commissioner: 1) Bureau of Nutrition Services; 2) Bureau of Children's Health; and 3) Bureau of Women's Health. The Associateship has administrative responsibility for most of the TDH programs and funding streams dedicated to women and children's health including Title V MCH and CSHCN, Medicaid – EPSDT medical and dental, WIC, Family Planning – Titles X, XX, and XIX, Breast and Cervical Cancer Control Program, and the Medicaid Medical Transportation Program. As such, the Associateship is in a position to more effectively coordinate and collaborate across programs.

The Bureau of Nutrition Services includes the 1) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); 2) Farmer's Market Program; 3) Public Health Nutrition Program; 4) Electronic Benefits Transfer; and 5) BabyLove (Information and Referral Line for Maternal and Child Health programs). Mr. Robert Kissel is currently serving as the Acting Bureau Chief.

The Bureau of Children's Health is made up of five divisions which include the 1) Children with Special Health Care Needs Division; 2) Child Wellness Division; 3) Newborn Screening, Genetics and Case Management Division; 4) Oral Health Services Division; and 5) Texas Health Steps Division (EPSDT and Medical Transportation Program). Mr. Mike Montgomery served as Acting Bureau Chief since November, 1999 and was appointed Bureau Chief in April, 2000. Previously, Mr. Montgomery served as the Bureau Chief for Nutrition Services and was the State WIC Director. Doctor Susan Penfield remains the State Title V CSHCN Director.

The Bureau of Women's Health is a new Bureau that was created as part of the Associateship realignment. This new Bureau includes the 1) Division of Family Planning (Titles V, X, XIX,

and XX), 2) Women's Health Laboratory, 3) Division of Breast and Cervical Cancer Control Program (moved from Bureau of Chronic Disease), 4) Maternity and Perinatal Health 5) Office of Special Projects which includes the Texas Breastfeeding Initiative, Domestic Violence Prevention Program, Male Involvement Project, and 7) a newly formed Office of Women's Health. Ms. Margaret Mendez was named Bureau Chief in December, 1999. Previously, Ms. Mendez served as Director for the Breast and Cervical Cancer Control Program.

Program profiles for each of the programs listed above are included in Appendix A. Each profile includes a general program description; a breakdown of services by direct health care, enabling services, population-based services, and infrastructure services; a definition of the target population; program eligibility requirements; and the program mandate/authority.

In addition to the three Bureaus, the Associateship has four support Divisions that report to the Associate Commissioner and include the 1) Financial Management Division; 2) Research and Public Health Assessment Division; 3) Quality Assurance and Monitoring Division; and 4) Automation Division. These Divisions support all of the Associateship programs and activities.

In November, 1999 the Associate Commissioner created a new position for State Title V Director. The Title V Director reports to the Associate Commissioner and is responsible for general administration of the State Title V Program. The Director coordinates with the Associate Commissioner, Bureau Chiefs, Division Directors and Title V CSHCN Director to assure integrated program planning for women and children's programs, appropriate resource allocation, and effective implementation, monitoring and evaluation of Title V Program across the Associateship and TDH. The Title V Director is responsible for overseeing the development and submission of the MCH Annual Report and Application and coordinates information sharing and reporting with HRSA (Federal and Regional), AMCHP and other Federal agencies (related to MCH activities). Ms. Debra Wanser was appointed State Title V Director in November, 1999. Formerly, Ms. Wanser was Director, Special Projects for the Associateship and in that capacity assisted the Associate Commissioner (then State Title V Director) with management of the Title V Program.

TDH and Associateship for Community Health and Resources Development organizational charts are located in Appendix B.

State Statutes

TDH has provided health services for women and children since 1918 and services to CSHCN since 1933. An overview of the State Statutes that directly relate to Title V MCH and CSHCN programs are listed below.

Maternal and Infant Health Improvement Act (MIHIA)

In 1985, the Texas Legislature passed MIHIA, which enabled TDH to establish a model health care program offering a comprehensive array of perinatal services to low-income, high-risk, pregnant women and infants who were not eligible for Medicaid. In 1995, the Texas Legislature passed Senate Bill 1229 to amend MIHIA. This legislation supported health

improvements for women and infants by promoting health education, providing assurance of reasonable access to safe and appropriate perinatal services, and improving the quality of perinatal care by encouraging optimal use of health care resources. TDH has passed rules to establish minimum standards and objectives to implement and monitor a statewide network of voluntary perinatal health care systems at a regional level. TDH will further develop policies for health promotion and education, risk assessment, access to care, and perinatal system structure including the transfer and transportation of pregnant women and infants. Finally, TDH will develop and maintain a perinatal reporting and analysis system to monitor and evaluate perinatal patient care within each region. TDH will provide support to the Perinatal Resource Coordinating group in each of the public health regions and promote coordination and cooperation within Texas and among neighboring states for perinatal care.

Children With Special Health Care Needs Services Program Act

In 1999, the 76th Texas Legislature passed Senate Bill 374 which amended the long-standing Chronically Ill and Disabled Children's Services Program Act. The program changed its name to Children with Special Health Care Needs Services Program effective September 1, 1999. By July 1, 2001, the amended Act requires the program to change its eligibility requirements and scope of services. The program will replace the current list of specific eligible medical diagnoses with a much broader functional definition of children with special health care needs. Also, the assets test will be eliminated. The program will offer a more comprehensive array of health care benefits comparable to the state's CHIP program and will also provide expanded family support services. Waiting lists will be established as necessary when service demands exceed budgetary limitations.

The program will join with CHIP, Medicaid, THKC, and other health care delivery partners to support the development of an integrated and comprehensive state health care systems for CSHCN and their families with a single point of entry/eligibility and a seamless administrative/claims payment structure. The program will join with other family support and long term care service providers to improve the availability, access, coordination, and simplicity of statewide service systems that support families in caring for their children in their homes and natural environments.

Newborn Screening Program

In 1965, the Texas Legislature passed legislation establishing the Newborn Screening Program and gave TDH the authority to implement the program. All Texas newborns are screened for phenylketonuria (PKU), galactosemia, sickling hemoglobinopathies (including sickle cell disease), congenital adrenal hyperplasia, and hypothyroidism.

The law requires that all newborns who have been screened and found to be presumptively positive for heritable diseases receive follow-up. Children at or below 200 percent FPL may receive services through the Children With Special Health Care Needs Services Program, including medical care, case management, and necessary dietary supplements. Individuals with PKU may receive dietary supplements at no cost or reduced cost, based on family income. In 1989, the 71st Legislature amended Chapter 31 of the Insurance Code to provide for health insurance coverage for PKU formula, similar to that for prescription drugs. Title V is

providing funds to pilot the use of medical foods in managing PKU.

Special Senses and Communications Disorders Act

In 1989, the 71st Legislature passed the Special Senses and Communications Disorders Act for the purpose of establishing a program for early detection of children from birth to 20 years of age who have special senses and communications disorders and need remedial vision, hearing, speech and language services. Early detection and remediation of those disorders provide individuals with the opportunity to achieve appropriate academic and social status through adequate health and education intervention.

Another requirement of this Act is the registration of audiometric equipment with TDH. The Bureau of Children's Health Audiometric Laboratory provides support for the Vision and Hearing Screening Program by annually calibrating and repairing the 666 audiometers owned by TDH and by loaning this equipment to day care centers, private schools, small school districts, and home school groups for hearing screening to comply with state requirements.

House Bill 714 of the 76th Legislature requires birthing facilities to offer hearing screening for newborns. TDH is required to certify screening programs at all birthing facilities and to provide data tracking software and technical assistance to all Medicaid facilities. The legislation further requires TDH to ensure access to appropriate Early Childhood Intervention (ECI) services and requires inclusion of newborn hearing screening services under Medicaid and any health benefit plan covering children. Intervention services for children under 200 percent of poverty not eligible for Medicaid or CHIP will be provided through the Title V Program for Amplification of Children of Texas (PACT).

Birth Defects Monitoring Program Act

In 1993, the 73rd Legislature gave TDH authority to establish a Birth Defects Surveillance and Registry program for the purpose of identifying and investigating certain birth defects in children and for maintaining a central registry of birth defects cases. The program is required to provide information to identify risk factors and causes of birth defects, conduct interview studies about the causes of birth defects, support the development of strategies to prevent birth defects, and maintain birth defects data in a central registry. Children with birth defects receive case management for assistance in applying for financial or medical assistance available through existing state and federal programs, including the CSCHN Program and Medicaid.

Abnormal Spinal Curvature in Children Act

Under Chapter 37, the TDH Spinal Screening Program facilitates the detection of abnormal spinal curvature in children through spinal screening in Texas schools. The program provides training and certification to spinal screener instructors and spinal screeners; approves spinal screening training programs, establishes standard spinal screening tests and referral criteria, monitors the quality of spinal screening activities, issues reporting forms, provides educational materials to assist spinal screening activities, and maintains records of approved instructors and screeners.

Midwifery Act

TDH is responsible for administering the Midwifery Program to assure annual documentation of direct entry midwives (as distinguished from certified nurse midwives) and interacts with the Midwifery Board and its committees. The Midwifery Program maintains a roster of annually documented midwives, publishes a basic midwifery information manual, compiles midwifery statistics, and processes complaints against midwives. The Midwifery Program is advised by the Midwifery Board, which is appointed by the Board of Health. The Midwifery Board investigates and resolves complaints against midwives, approves rules and standards of practice for midwives, and advises the Board of Health on other midwifery issues. The Midwifery Board also approves basic midwifery courses, certification exams and continuing education courses.

Oral Health Improvement Act

TDH is responsible for establishing the Oral Health Improvement Services Program to provide comprehensive oral health services to eligible individuals. Oral health services include direct preventive and treatment services, fluoridation of community water supplies, oral health education and promotion activities, sealant programs, continuing health education programs for providers, public health education in preschools, schools and adult education programs, outreach activities to promote awareness of oral health service programs, and activities to address provider availability across the state. The program conducts field research and prepares reports relating to the need for and availability of oral health services. TDH is not required to provide services unless funds for oral health services are appropriated to TDH. In FY2000, TDH received significant reductions to the Public Health Services Block Grant and the Fluoridation Program funding was eliminated. The Texas Title V Program has provided funding to the Fluoridation Program to continue funding new fluoridation systems and to upgrade existing system in need of repair.

Injury Prevention and Control Act

This legislation establishes a list of reportable injuries, which include spinal cord and submersion injuries and elevated blood lead levels. The Board of Health has the authority to establish rules to designate blood lead concentrations and ages of children that must be reported. TDH has the authority to seek, receive, and spend funds on identifying, reporting, and preventing injuries; to conduct epidemiological studies; to evaluate trends; to make inspections and investigations; and to establish a childhood lead registry.

Child Passenger Safety Seat Systems Act

This legislation permits TDH to establish a program to distribute child passenger safety seats to indigent persons and allows the Board of Health to adopt program eligibility rules.

Sudden Infant Death Syndrome (SIDS) Act

New legislation passed during the 76th session requires that the death of a child 12 months old or younger be reported to the Justice of the Peace, medical examiner, or other proper official if the child dies suddenly or is found dead and the cause of death is unknown. The official is required to inform the child's parent/guardian that an autopsy will be performed. The law directs TDH to reimburse a county up to \$500.00 per autopsy if the cause of death is SIDS.

Previous law requires TDH to develop a model program to provide information and follow-up consultation about SIDS and to promote public awareness and understanding of SIDS.

1.5.1.2 Program Capacity

In FY2000, the Texas Title V Program provided Title V and general revenue funds for direct, enabling, population-based and infrastructure building activities around preventive and primary care services for pregnant women, mothers, infants, children, adolescents and children with special health care needs. The majority of MCH services are provided through contracts with local providers including local health departments, universities, hospital districts, school districts, local coalitions and individual providers. Contracts are awarded through a competitive request for proposal process. In areas of the state where no local contractors exist, MCH direct services are provided by the 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 percent FPL and not eligible for Medicaid. MCH direct service providers are required to screen for Medicaid eligibility and to refer those individuals who are potentially eligible.

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 majority of CSHCN services are provided through individually enrolled providers across the state. These providers include, but are not limited to, physicians, dentists, hospitals, out-patient hospitals, occupational therapists, physical therapists, speech-language therapists, home health agencies, pharmacies, laboratories, orthotists, prosthetists, and a number of other specialty care providers.

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

Preventive and primary care services for pregnant women, mothers, and non-pregnant women include: prenatal services (initial, return and postpartum visits, ultrasound, nutrition education and case management); family planning services (initial visit, pregnancy test, depo-provera, oral contraceptives, IUD insertion and removal, norplant insertion/removal, tubal ligation, vasectomy, nutrition education, annual gynecology examinations); dysplasia services (initial and return visits, colposcopy, biopsy, and conservative treatment). The TDH Women's Health Laboratory and the TDH Bureau of Laboratories provide lab services associated with the primary care listed above for the MCH contractors. There is coordination with the Breast and Cervical Cancer Control Program to provide diagnostic services for women requiring dysplasia follow-up.

Primary care services for infants include well child, sick child and follow-up visits, nutritional visits, immunizations and case management. Other preventive services for infants include the

Newborn Screening Program (for five metabolic disorders) and the Universal Newborn Hearing Screening Program.

The Texas Breastfeeding Initiative provides breastfeeding promotion materials and services through WIC clinics, TDH clinics, hospitals, physicians' offices, private non-profit agencies, community health centers, home health nurses, and peer counselors. Implementation of *Mother Friendly Worksite Programs* assist new mothers by providing a suitable, private location to pump and store their milk when they return to work, and flexible work hours. The Baby Friendly Hospital Initiative Texas Ten Steps Hospital Program encourages hospitals to implement the *Ten Steps to Successful Breastfeeding* to help new mothers get off to a good start in the hospital.

A description of each of the programs and services may be found in the program profiles located in Appendix A.

Preventive and Primary Care Services for Children

Primary care services for children include well child, sick child and follow-up visits, nutritional visits, and case management, as well as prenatal and family planning services listed above, as needed. Title V also provides funding for dental service (preventive services and restorative treatment) for children and adolescents.

The Genetics program contracts for genetic clinical services for mothers, infants and children through local providers, provides genetics clinical services in the El Paso area, and provides medical consultation for two laboratories in Denton concerning chromosome and biochemistry.

This Vision and Hearing Screening program provides annual screening for children four years of age through ninth grade, who are enrolled in a licensed child care facility, group day care homes or public or private school. The program trains and certifies vision and hearing screeners in schools and child care facilities across the state; provides technical support to their screening programs; and maintains annual records of numbers of children screened, referred, and treated for vision or hearing problems.

The Program for the Amplification of Children in Texas (PACT) provides services related to hearing loss and hearing aid(s) for low-income children birth through 20 years of age. PACT operates a fee-for-service program and contracts with approximately 150 audiologists across the state who provide hearing loss identification, diagnosis and treatment. Children not eligible for Medicaid are covered under Title V funding.

The 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.

The Take Time For Kids Program is a public-private partnership between the Texas Department of Health (TDH), state and community agencies, advocates, and businesses working together to promote the health and safety of children. The program goals are to: 1) increase practice of positive parenting by expanding parenting education; 2) promote preventive health care; 3) support the coordination and growth of community efforts and resources to maximize the healthy development of children.

The Spinal Screening Program facilitates the detection of abnormal spinal curvature in children ages ten and thirteen in Texas schools. The program 1) provides training and certification to spinal screener instructors and spinal screeners; 2) approves spinal screening training programs; 3) establishes standard spinal screening tests and referral criteria; 4) coordinates spinal screening activities of school districts, private schools, and other entities involved in spinal screening; 5) monitors the quality of spinal screening activities in Texas; 6) issues reporting forms; 7) provides educational materials to assist spinal screening activities; and 8) maintains records of approved instructors and screeners.

The Male Involvement Project is jointly funded by Title V and Title XX. This Project funds and coordinates two Male Involvement research projects in the Houston and Austin areas for low income adolescent males and men ranging in age from 12-25 years old. The primary goal of each project is to reduce the number of teen pregnancies within the target population. Projects are community based and involve the use of community coalitions to design and oversee each project. Currently, coalition-building activities are underway in the Rio Grande Valley and El Paso where it is planned that two more projects will be funded in the future. Projects are designed to help participants learn healthy decision making skills through the following kinds of activities: mentoring, job readiness, peer education, support groups, and case management, or by some other creative means determined by the community coalition overseeing the project.

A description of each of the programs and services may be found in the program profiles located in Appendix A.

Children with Special Health Care Needs Services

TDH operates the Children with Special Health Care Needs Services Program (Texas' Title V CSHCN program, formerly the Chronically Ill and Disabled Children's Services Program). Currently, CSHCN services are available only for children who have certain specific diagnoses from birth until 21 years of age (except adults with cystic fibrosis, who are eligible for services beyond age 21) and who meet financial, asset, and residency requirements. Citizenship and documented immigration status are not required.

The CSHCN Services Program provides health care services that are related to the covered diagnosis; examples are physician visits; hospitalization; orthotics and prosthetics; medical equipment and supplies; nutritional supplements; nutritional counselling; medications; speech, language, physical, and occupational therapy; and meals, lodging and transportation to receive medical treatment. The CSHCN Services Program is now undergoing a major redevelopment

process as discussed in Sections 1.4 and 1.5. Redevelopment will result in a program that is open to children based on their being CSHCN, not on their diagnoses; and a program that is more comprehensive, with broader benefit coverage and the capacity to supplement health care coverage that is inadequate to meet the needs of CSHCN. The CSHCN program will also offer an array of family supports such as respite. The CSHCN program will continue to be the payer of last resort, after Medicaid, CHIP, and private insurance. A waiting list will be instituted if necessary.

Case management (or care coordination) services are available to help families with accessing necessary services. TDH provides case management services through contracts with community-based entities in some parts of the state. In areas of the state where these contract services are not available, TDH Public Health Regional staff provide case management services. A key purpose of these programs is to provide and promote family-centered, community-based, coordinated care, including care coordination services for CSHCN. These programs also facilitate the development of systems of care for CSHCN and their families. The regional and contractual service providers also facilitate the development of new services for CSHCN, enlarging the available systems of care for CSHCN and their families. Policy and contract administration for the Title V case management contracts is provided by CSHCN staff and the Contracts Management Section staff. Policy and oversight for the regional and medicaid case management services, including Medicaid Pregnant Women and Infants Case Management (PWI) and Medicaid Medical Case Management, is provided by the Case Management Section in the Bureau of Children's Health. Care coordination/case management of the Medically Dependent Children Program (MDCP, a 1915c Medicaid waiver) is integrated into the regional case management structure, with oversight in the CSHCN Division.

Case management/care coordination services are provided to children enrolled in the CSHCN program as well as for other children seeking health care and other services. In 1998 Medicaid Medical Case Management was implemented to provide case management/care coordination services for children and adolescents enrolled in Medicaid. As the number of Medicaid case management providers increases, it is expected that the Regional staff's direct involvement will decline. The Title V Regional staff will continue to provide an oversight and quality assurance role for the Medicaid Medical Case Management program.

Children with SSI have been a special target population for case management outreach for many years, even as other "rehabilitative services" have been provided increasingly through Medicaid. Children with SSI are automatically eligible for Medicaid in Texas. The Social Security Administration contracts with the Texas Rehabilitation Commission (TRC) to conduct disability determinations for SSI. The applications of children aged 16 and under who are determined to be eligible for SSI are sent to TDH, Bureau of Children's Health, Case Management Section, for distribution to the TDH Public Health Regional Offices. Regional staff contact all families of SSI-eligible children via telephone or mail and arrange for services as needed, facilitating access to the array of Medicaid services.

Title V CSHCN also provides a limited amount of funding for the Purchase of Service Program

for SSI beneficiaries. This program purchases services and equipment not available through the Medicaid program or other resources. Van lifts have been the service most requested in the past, but effective May, 2000, a pilot program was implemented to expand services to include minor home modifications (not permanent structure), short term or emergency respite, special equipment and supplies, and parent training.

Development of Systems of Care

Within the Bureau of Children's Health, the Children with Special Health Care Needs Division is responsible for CSHCN-related activities for TDH. Under the leadership of Susan Penfield, M.D., the CSHCN Division leads development activities for the promotion of systems of care for CSHCN. Current initiatives led by the CSHCN division staff include implementation of legislation from the 76th Texas Legislature requiring restructuring of the CSHCN (formerly Chronically Ill and Disabled Children's Program (CIDC)); planning for the transition of the Medically Dependent Children Program (MDCP) Medicaid waiver program to another state agency; involvement in several initiatives of the Texas Health and Human Services Commission, such as the Children's Long Term Care Policy Council and the Long Term Care Waiver Consolidation Workgroup; participation in an initiative on cultural competence for CSHCN; and implementation of two new grant-funded initiatives which are being transferred from the Texas Health and Human Services Commission.

CSHCN Redevelopment

The CSHCN/CIDC Program has been mandated to be restructured to serve additional children on the basis of their being CSHCN instead of on the basis of their ICD9 codes and to meet some of the nontraditional support service needs of families. The health benefits will also be more comprehensive than in the existing limited, categorical program and will align better with CHIP and Medicaid services for CSHCN. The CSHCN Program redevelopment planning process for this redesign is underway. Program staff began an internal effort early in FY 2000. A lead group for redevelopment was formed and the global process for the redevelopment was designed. As a result, several core committees were formed to facilitate the redevelopment process. Leaders were established for each of the groups and regular meetings commenced. It was anticipated that new program rules would be drafted during the summer of 2000, with draft rules going to the Board of Health in the Fall of 2000. Implementation is mandated by the legislation to occur by July 1, 2001.

In addition to the internal TDH activities, external stakeholder input was sought. Integral to this process was the involvement of the CSHCN Advisory Committee, an 18-member committee appointed by the Board of Health (BOH) and responsible for advising the BOH on matters of importance to children with special health care needs and their families. This CSHCN Advisory Committee was enlisted to spearhead the effort to gain consumer and stakeholder input and participation. The committee is actively involved in the CSHCN Redevelopment process and will meet to consider the draft rules in August of 2000. The CSHCN Advisory Committee recommendation about the draft rules will be submitted with the draft rules to the Board of Health. Several members of the CSHCN Advisory Committee are actively involved in policy deliberation necessary to draft the rules development. Other mechanisms for external input

have included regional focus groups and a statewide public hearing. A section addressing CSHCN Redevelopment was added to the TDH website. An email distribution list facilitates communication with for interested individuals and entities.

The program's health care coverage and other services will be provided to CSHCN and their families through service systems that are family-centered (support and encourage active participation by the child's parents and/or other primary caregivers in the service planning and delivery process), coordinated (support linkages and smooth transitions between different programs, services and providers), and community-based (promote grassroots, community-level involvement in the provision of services in order to bolster natural and culturally competent support systems).

Medically Dependent Children Program (Medicaid Waiver)

The MDCP Medicaid waiver was legislatively transferred to the Texas Department of Human Services from its current administrative home in the CSHCN Division. This waiver serves children with significant medical needs and currently provides Medicaid and waiver services to over 900 CSHCN. Efforts of the division staff are focused on making the transition of administrative oversight as family-friendly as possible, hoping to avoid any problems in delivery of services to families. The transfer is planned to occur by September 1, 2001.

Medicaid Managed Care

CSHCN staff have been actively involved for two years in the development of a model for services to children with special health care needs in managed care. This work, under the leadership of the State Medicaid Office, has focused on defining CSHCN for the purposes of Medicaid managed care, developing an identification mechanism for use in Medicaid managed care, piloting this mechanism using the definitions developed, and designed quality assurance processes to assure quality care to CSHCN in managed care. This work was mandated by the Texas Legislature (SB 1165). The pilot testing occurred recently in Bexar County, Texas (San Antonio) and data is being collected and analyzed at this time. It is anticipated that modifications to the process will be made based on the results of the data from the pilot. Eventual statewide implementation is anticipated, pending completion of the model development.

Cultural Competency

TDH, through efforts led by Lesa Walker, M.D., head of the Systems Development Section within the CSHCN Division, was awarded a grant from the National Center on Cultural Competency. The Texas CSHCN Program is one of several states participating in the national center's effort to survey cultural competency. In February, staff from the National Center on Cultural Competency visited TDH and conducted an initial training and technical assistance visit. They held a focus group for consumers/parents of CSHCN as well. They provided the CSHCN Division with copies of a cultural competency survey tool to be used to gather information from several partner agencies and organizations. In June, the CSHCN Division returned the completed surveys to the national center. The survey results will be analyzed and the national center staff will return to Texas in the fall of 2000 to provide a follow up technical assistance session with the CSHCN and TDH staff.

Interagency Collaboration

The Texas Health and Human Services Commission (HHSC), in coordination with the health and human service agencies under its administration, have identified several strategic priorities that directly impact CSHCN and their families. CSHCN Division staff, along with relevant staff from the other agencies, participate in these inter-agency initiatives. These initiatives include 1) expanding the availability of and access to respite services; 2) expanding opportunities for community-based services; and 3) improving coordination of children's special initiatives at the community level.

HHSC will transfer responsibility for several children's initiatives to TDH as operating agency by the end of FY 2000. Transferring to TDH to be administered by the CSHCN Division are the:

- C Texas Family Support Initiative - a three year federally funded initiative intended to demonstrate the use of local family support councils in three locations to facilitate the development and delivery of family support services.
- C Traumatic Brain Injury Initiative- a federally-funded initiative to establish mechanisms to develop a registry for individuals with brain injury and their families. In addition, it seeks to build a database of individuals with brain injury within Texas who could benefit from service. The initiative supports a state council to address issues and concerns for this population and to write recommendations and a plan for a system of care for individuals with brain injury. The initiative is particularly focused on children. The CSHCN Division will support the work of the council and will provide staff to assist with the activities defined in the project.

In addition, a state-level policy council was established to focus on long term care services for children. This policy council, The Children's Long Term Care Policy Council, is composed of consumers, parents, advocates, providers, representatives of community and faith-based organizations and state agency representatives. The council is charged with making recommendations to the state regarding issues of children's long term care in Texas. TDH and other agencies support the council. A member of the TDH regional social work staff sits as a voting member on the Council and the Title V CSHCN Director, Susan Penfield, M.D., is the agency liaison to the Council.

CSHCN staff also attend and help support meetings of the Promoting Independence Board, a board established by the HHSC to work with Olmstead related issues and other community based living issues in Texas.

CSHCN staff are participating with family partners in the Texas Integrated Funding Initiative (TIFI) Consortium to develop community based systems of care across traditional agency boundaries. The targets of the TIFI are children under 18 who are receiving or are at risk of needing residential mental health services. This model may be applicable to other conditions.

The CSHCN Division supports the work of the "On the Right Track" (ORT) grant. ORT is a four-year project funded by the Centers for Disease Control and addresses prevention of

secondary disabilities. One major development in FY 2000 has been the website for ORT (<http://www.tdh.state.tx.us/disability>). This site provides information, linkages and support for families and providers of CSHCN and describes the many facets of the project.

CSHCN Division staff have participated in or led workgroups to foster many additional activities relating to CSHCN. Major efforts and ongoing coordination with Medicaid/CHIP and Texas Healthy Kids center on assuring interface and coverage for all eligible CSHCN in Texas via some vehicle for health services and ancillary benefits. Public and private partnerships have been emphasized in this ongoing effort. CHIP implementation is underway at this time. CSHCN services are anticipated to augment the program benefits of both Texas Medicaid and CHIP. Of significance will be the potential for families with CSHCN to access family support services via the new CSHCN program. Attention to ease of access and the elimination of duplication in the delivery of case management and family supports is a primary focus in this work.

1.5.1.3 Other Capacity

Tables 1 and 2 provide the number and types of full-time equivalent personnel funded by the federal-state Title V program. This information is based on the Title V administrative allocation budget for FY2001 as of April, 2000. Table 1 shows a total of 318 positions funded in the Associateship for Community Health and Resources Development (TDH Central Office in Austin) with federal Title V and state general revenue funding. Table 2 shows a total of 368 positions funded with federal Title V and state general revenue funding in TDH Public Health Regional Offices.

JOB DESCRIPTION	CENTRAL OFFICE*
Accountant	8
Administrative Tech.	66
ADP Supervisor	2
Chemist	3
Clerk	7
Clinical Social Worker	1
Contract Specialist	1
Data Base Administrator	4
Data Entry Operator	5
Director	14
Executive Assistant	7
Information Specialist	1
Laboratory Technician	7
Manager	3
Medical Technologist	29
Microbiologist	34
Network Specialist	20
Nurse	15
Office Machine Service	1
Public Health Technician	7
Physician	7
Planner	1
Program Administrator	12
Program Specialist	21
Programmer	18
Purchaser	2
Research Specialist	4
Secretary	1
Staff Services Officer	4
Statistician	3
Systems Analyst	6
System Support Specialist	4
TOTAL	318

* Includes ICES, ADS, Grants Management, Injury Prevention

Positions	PHR	TOTAL							
	1	2/3	4/5	6	7	8	9/10	11	
Accountant	0	0	0	0	0	0	0	1	1
Administrative Tech.	0	2	1	8	8	6	8	9	42
Caseworker	0	0	0	0	0	0	0	3	3
Clerk	0	0	10	4	6	6	2	10	38
Custodian	0	0	0	0	0	0	0	1	1
Epidemiologist	0	1	0	0	0	0	0	0	1
Human Service	3	13	12	10	6	9	5	10	68
Human Service Tech.	2	5	2	5	3	13	9	11	50
Inventory Coordinator	0	0	0	0	1	0	0	0	1
Laboratory Tech.	0	0	0	0	0	0	0	1	1
Licensed Voc. Nurse	0	0	0	0	0	2	0	8	10
Manager	0	0	0	0	1	0	0	0	1
Medical Aide	0	0	0	0	0	0	0	2	2
Nurse	2	6	11	10	11	11	16	15	82
Nutritionist	0	0	2	1	0	0	0	0	3
Physician	0	0	1	0	0	0	0	0	1
Program Administrator	2	4	4	3	1	3	5	3	25
Program Specialist	1	2	2	3	2	2	1	2	15
Public Health Tech.	0	1	3	0	4	4	6	1	19
Radiological Tech.	0	0	0	0	0	0	0	1	1
Secretary	0	2	0	0	1	0	0	0	3
TOTAL:*	10	36	48	44	44	56	52	78	368

* Includes 4 Local Health Department and the South Texas Women's Hospital in Harlingen.

Within the Title V program, each staff member uses planning to some extent to influence the course of his or her daily activities and responsibilities. However, because directors have the greatest amount of contact with the environment and thus are in best position to know what their programs will face in the future, they make current program operations and policy decisions in the light of their future effects. Directors include bureau chiefs, MCH and CSHCN Title V directors, and program division directors. In some instances, directors may delegate the decision-making function to selected program specialists who, on a routine basis, play the role of catalysts in or facilitators of the planning process. It is important to note that some TDH program specialist job descriptions are similar to those of conventional planners. On the other hand, researchers and statisticians provide data and information, which are essential ingredients in the planning process and decision-making. Researchers appraise the performance of interventions and programs, then propose the necessary adjustments to bring the program to the desired objectives. Statisticians collect primary and secondary data from multiple sources and critically analyze data to illustrate meaningful associations.

Nine parents of CSHCN serve on the TDH CSHCN Advisory Committee. Their role is to advise the Board of Health as well as the Bureau of Children's Health on policies, programs, and systems development for CSHCN and their families. Additionally, the State Title V CSHCN posted a program specialist position to hire a parent of a child with special health care needs to consult in developing and implementing a plan to enhance parent participation in program and policy activities. A top candidate has been selected and offered the job. The new staff member has an extensive knowledge of issues related to CSHCN and their families, and is a close relative to a child with special health care needs. She will join the program in July, 2000.

In addition to the CSHCN Advisory Committee, there are six advisory committees that support Title V and related programs within the Associateship. There are a total of 96 members for all MCH and CSHCN advisory committees; of those, 31 members are consumers and/or advocates. A summary of the CSHCN and other MCH-related advisory committees is listed in Table 3.

Advisory Committee	Total Members	Consumer/Advocate Members
Children with Special Health Care Needs Advisory Committee	12	3
Breast and Cervical Cancer Control Program Advisory Committee	6	2
Family Planning Advisory Committee	11	2
Oral Health Services Advisory Committee	11	3
School Health Advisory Committee	16	6
Adolescent Health Advisory Committee	18	6
"On the Right Track" (CDC Grant) Committee	22	9

Appendix C contains summaries of the qualifications of senior level employees.

1.5.2 State Agency Coordination

The organizational relationship of the Texas Department of Health to the other health and human services has been described in Section 1.5.1.1 Organizational Structure. Title V staff within the Associateship for Community Health and Resources Development have ongoing program and project-specific relationships with all the agencies under the umbrella of the Texas Health and Human Service Commission, as well as with other agencies not under the HSSC, such as the Texas Education Agency.

The Title V program has longstanding contractual and collaborative relationships with local health departments (LHDs), federally qualified health centers (FQHCs), and FQHC look-alikes. LHDs and FQHCs are actively involved in local health planning, including development of coalitions for women and children's services. Title V also maintains ongoing collaborative relationships with university-based education and clinical services programs and with tertiary care facilities. Title V contracts with LHDs, FQHCs, universities, and other community-based providers for MCH and CSHCN direct and enabling services, population-based services, training, assessment and evaluation, and other population-based and infrastructure building activities.

University faculty and staff serve on TDH committees, task forces and Title V staff also participate in university and facility-based projects by assisting with development and implementation of grant projects and new programs. All of the above organizations enhance the capacity of the Title V program to deliver direct, enabling and population-based services and to build the public health infrastructure for all women and children in Texas.

Healthy Start Projects

Title V Program staff are participating with the Texas Healthy Start Projects in developing a stronger collaboration between Healthy Start and Title V. As we recognize our mutual goal of improving perinatal health outcomes for mothers and children, we identified some activities intended to increase collaboration. Those activities include the following:

- C Healthy Start Projects and the Title V MCH Program will hold quarterly meetings for continued planning and collaboration. These meetings can serve as a forum for related topics and include other invited guests who represent programs/activities related to perinatal health. Some of the programs identified include Texas Health Steps (Title XIX-EPSDT), Children's Health Insurance Program (Title XXI), Texas Healthy Kids Foundation, HIV/STD Program and WIC.
- C Title V MCH Program will facilitate establishing working relationships between the Healthy Start Projects and the TDH Public Health Regional Directors and the MCH Regional Coordinators in each of the Healthy Start Project locations.
- C Title V MCH Program will facilitate establishing working relationships between the TDH MCH contractors and the Healthy Start Projects. Further, the Title V MCH Program will explore developing a requirement (either through policy or contract) that all TDH MCH contractors coordinate with Healthy Start Projects (in their service area).

- C Healthy Start Projects will participate in planning and developing a “Women’s Health Agenda” (a statewide initiative, coordinated by TDH, Bureau of Women’s Health).
- C Healthy Start Projects have been asked to provide input to the Bureau of Women’s Health in planning and implementing the Perinatal Regionalization Rules in FY2001. The Healthy Start Projects could provide leadership and be key participants at the regional level.
- C Title V MCH Program will include Healthy Start Projects on MCH list serves and other distribution lists to facilitate sharing of information. Jointly, we will explore linking MCH web sites and Healthy Start Project web sites.
- C Under the leadership of the Region VI HRSA Office and the Healthy Start Projects, Texas Title V MCH Program will participate in planning and conducting a Region VI conference on maternal health issues.

In addition, Title V staff were instrumental in facilitating submission of an application for a new Healthy Start Grant for Eliminating Racial/Ethnic Disparities. Title V staff helped identify potential applicants and provided technical assistance and consultation for an applicant in Brownsville, Texas (lower Rio Grande Valley along the Texas - Mexico Border). In June, the applicant was notified that their proposal was approved.

Other

Specific areas of collaboration between TDH Title V staff, state agencies, universities, health facilities, and community-based entities are outlined in several sub-sections of Section 1 and Section 3. Those areas of collaborations of particular note include activities within the Office of Women's Health, the Youth Health Initiative, the CSHCN Redevelopment, and CHIP implementation.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See Supporting Documents: Forms 3, 4, & 5.

2.2 Annual Number of Individuals Served

See Supporting Documents: Forms 6, 7, 8, & 9.

2.3 State Summary Profile

See Supporting Document: Form 10

2.4 Progress on Annual Performance Measures

Direct Health Services

01

Type: Capacity
Population: CSHCN

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

Action Plan

1. Activity: Provide CSHCN program services to SSI beneficiaries who become ineligible for Medicaid.

Progress Report: All 637 SSI beneficiaries who lost Medicaid coverage due to other available resources were referred to the state CSHCN program as well as to other applicable programs such as CHIP, Medicaid Waivers, community resources, etc. by TDH regional social work staff.

02

Type: Capacity
Population: CSHCN

The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Action Plan

1. Activity: Identify ways to increase the number of providers to meet the health care needs

of the CSHCN population.

Progress Report: Data were obtained from the state's CSHCN program regarding CSHCN providers by region, county, and provider type. The next steps are to: 1) analyze data to determine areas of the state that need particular types of providers, and 2) work with TDH statistical staff to design and conduct surveys of CSHCN families and regional staff.

2. Activity: Improve dissemination of policy changes both internally and to regional staff to ensure appropriate access to and utilization of available services by CSHCN program clients.

Progress Report: The process in place for disseminating policy changes is:

- 1) Obtain policy issues from internal and external TDH central office and regional staff and from NHIC staff.
- 2) TDH Central Office staff and NHIC staff have a pre-Child Health Policy Committee meeting to discuss the impact of any policy operations if changes are made to the program or its policies.
- 3) Revised program policies are presented, reviewed, and discussed at the Child Health Policy Committee meeting, which is attended by internal and external TDH central office and regional staff and by NHIC staff.
- 4) Program policies approved by the Child Health Policy Committee are routed internally for final sign-off approvals.
- 5) Finally approved program policies are then disseminated to the internal and external TDH central office and regional staffs and to NHIC staff for implementation.
- 6) Agendas, minutes, and program policies presented at each Child Health Policy Committee meeting are kept on file by the CSHCN Policy Development Unit for historical record.

Enabling Services

03

Type: Capacity

Population: CSHCN

The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."

Action Plan

1. Activity: Active participation of CSHCN staff in Medicaid Managed Care rollout to ensure medical homes for CSHCN.

Progress Report: During FY99 Medicaid Managed Care had not yet implemented mechanisms to identify and count CSHCN; however, of the 8,803 CSHCN served by TDH, 7,837 (90%) had medical homes. Quarterly data on the number of children with medical homes are now collected by CSHCN case management contractors.

The Houston Star/Star + Plus CSHCN subcommittee meets quarterly "as needed" to address issues relating to Medicaid Managed Care and CSHCN.

The Dallas rollout of Medicaid Managed Care is in progress, and TDH central office and regional CSHCN staff attend CSHCN subcommittee meetings in Dallas. Enrollment and provider availability have been primary issues for Dallas.

2. Activity: Develop an operational definition of CSHCN for managed care and other insurance programs such as CHIP pursuant to Senate Bill 1165 in order to determine baseline data for CSHCN.

Progress Report: Pursuant to Texas Senate Bill 1165, the Title V CSHCN program directors participated in continued planning to operationalize a definition of CSHCN, and they attended monthly SB 1165 workgroup meetings. The prototype definition for "complex CSHCN" is being piloted in Bexar County for 6 months. An automation mechanism to flag identified children is also being piloted.

3. Activity: Establish a system of shared data between Medicaid Managed Care and the Title V program to facilitate the count of CSHCN with medical homes.

Progress Report: Progress on this activity was limited due to the delay in implementing Compass 21, TDH's new electronic billing system, and to related delays in TDH's obtaining access to managed care encounter data from contracted Medicaid HMOs. However, work on development of links continues.

4. Activity: Participate in CHIP policy development to ensure there is an adequate CHIP benefits package, including a medical home.

Progress Report: CSHCN staff actively participated in high level management planning activities for CHIP. The planning team included the TDH Bureau Chief for Children's Health Insurance (CHIP) and the Health and Human Services Commission Associate Commissioner for CHIP. CSHCN staff provided advice regarding the CHIP benefit plan, the CHIP application, and community-based outreach activities. The CHIP benefit package contains services needed by CSHCN and is similar to Medicaid coverage for CSHCN. CSHCN or their families may request specialists as their primary care physicians and receive case management services as part of the health plan. CSHCN staff actively

reviewed drafts for the following RFPs: HMO, Dental, Administrative Services, Community Based Organizations (Outreach) and Quality Assurance.

Population-Based Services

04

Type: Risk Factor

Population: Women & Infants

Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g. the sickle cell disease)(combined)].

Action Plan

1. Activity: Establish baseline data for the number of newborns with at least one newborn screen by developing program software that accurately measures the total number of babies receiving at least one newborn screen.

Progress Report: This activity is in the software acquisition stage. NBS staff met with OZ Systems, Inc. of Dallas, Texas, to review their software, SIMS, which is presently being used in the Sounds of Texas Newborn Hearing Screening Project. SIMS is a patient management system that has capabilities of population level aggregation, analysis, and monitoring. SIMS also creates the ability to identify and track outcome measures, for individuals and for entire populations. OZ Systems looks specifically at Texas newborn demographic data, hearing screens, and follow-up in an effort to establish a public health information system from birth; the primary focus of the system is Texas newborns.

NBS staff also met with Neometrics of New York. Neometrics is the supplier of NBS software and will present an upgraded Case Management System (CMS) and Metabolic Screening Database System (MSDS) to NBS staff. The new system includes a Graphical User Interface (GUI) and a set of tools which can generate a wide variety of reports without the need for a complex report writer. This system and tools result in faster and more effective follow-up services. The latest release of MSDS includes new client server architecture providing increased speed and reliability. Optional windows compatibility provides multi-tasking capability.

2. Activity: Expand the pilot study to educate mothers about newborn screening benefits and legal requirements in targeted areas with lower rates of newborn screening.

Progress Report: Increased parental knowledge about newborn screening encourages parents to bring their infants back to their primary care physician for the mandated second screen in a timely manner. Therefore, staff contacted

2,119 Texas obstetricians, from whom the following literature requests were filled: NBS brochures "Newborn Screening: For Your Baby's Health" (English — 61,190; Spanish — 27,552) and *Texas NBS Practitioner's Guide* — 269.

Staff contacted 86 Women, Infants, and Children (WIC) administrative sites to distribute the following NBS brochures "Newborn Screening: For Your Baby's Health" (English — 28,600; Spanish — 15,745) and NBS "Second Screen Reminder Cards" (English — 30,500; Spanish — 13,710).

NBS literature were prepared and legal requirements met for web site publication, which received 26,347 hits in FY99.

NBS staff distributed 3,986 *Practitioner's Guides* to NBS specimen submitters.

05

Type: Risk Factor

Population: Children

Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Action Plan

1. **Activity:** Continue statewide promotion and distribution of "My Child's Health Record" to all parents regardless of income.

Progress Report: Title V funding for the development and printing of the original brochure "My Child's Health Record" occurred in FY98. The TDH Immunizations Program was responsible for the ongoing distribution of this brochure, but were not able to fund printing of the brochure in FY99 and FY00. Title V will look at funding the brochure for FY01.

2. **Activity:** Participate in development of the immunization sections of the monthly "Texas Tots" magazine and distribute to Title V providers for their non-Medicaid clients.

Progress Report: "Texas Tots" was incorporated into the TDH Take Time for Kids initiative. To date, the publication is made available to the THSteps population.

3. **Activity:** Extend the use of the ImmTrac (automated immunization tracking system) to TDH regional clinics and TDH-funded agencies serving children.

Progress Report: During FY99, 43 out of 65 local health departments used ImmTrac. Assessment of user-friendliness and of the increase in children completing immunizations is still in progress.

4. Activity: Monitor Title V provider compliance with the TDH Immunization Division recommended immunization schedule.

Progress Report: TDH Quality Assurance Division continued monitoring activities on a regularly scheduled basis. In addition to regional quality assurance activities, there were 26 Central Office visits. About 90% or more of all contractors are reviewed annually for compliance with the immunization policies, and virtually all are in compliance.

06

Type: Risk Factor

Population: Children

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Action Plan

1. Activity: Provide family planning clinical and educational services to adolescents through TDH contractors.

Progress Report: In FY99, TDH regional clinics and contractors delivered family planning services and/or education to 63,360 adolescent clients ages 19 or younger using Title X and Title XX funds. Of those, 46,791 received clinical services and 18,569 attended teen group education. Once contractors expended all of their allocated Title XX funds, most continued to serve clients; but claims were not submitted for reimbursement and, therefore, numbers are not available. In addition, 12,501 adolescents received clinical services funded by Title V; 52,419 adolescents were served by Medicaid for family planning; and 15,050 adolescents received services from the Abstinence Education Program. The total for the Abstinence Education Program is not final, as reports are still being compiled.

2. Activity: Update and distribute state and county fact sheets to disseminate statistical data about teen pregnancy in Texas.

Progress Report: In FY99, a Texas state teen pregnancy fact sheet and individual county teen fact sheets were prepared. Samples of the fact sheet and information about how to order additional copies were sent to health agencies, schools, and other interest groups. Determination of usefulness was based on the resulting orders for more copies. The TDH Family Planning Program received 124 agency requests for the state fact sheet and 132 agency requests were received for county-specific fact sheets. Several of the requests were for large quantities. The demand for fact sheets from the public and from organizations is actually under-reported, because telephone requests were often not recorded and other sections within TDH also distributed the fact sheets upon request.

3. Activity: Work closely with one or more local community-based coalition(s) including at least one in the Texas-Mexico Border area which will address teen pregnancy reduction to identify interventions for which TDH could provide support.

Progress Report: TDH provided support to an existing coalition located in the 5th Ward of Houston, primarily by assisting with the development of an evaluation component. The East Austin Male Involvement Project conducted 13 meetings of interested coalition members in FY99. By the end of the fiscal year the group had progressed to a point where they were nearly ready to select a lead contractor and subcontractors for the project. The coalition is ongoing. Discussions are still underway for a Texas/Mexico community-based coalition in the towns of Brownsville and Matamoros to address teen pregnancy prevention.

07

Type: Risk Factor

Population: Children

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Action Plan

1. Activity: Continue statewide promotion and distribution of sealant educational materials to selected Texas schools.

Progress Report: During FY99, 19.7% of the third-graders examined has dental protective sealants on at least one molar. Of the third graders sampled, 69% received dental sealants on at least one permanent molar by the end of the demonstration project. The distribution of sealant educational materials continues but has not been standardized to measure uniform impact on the target.

2. Activity: Continue the management and maintenance of the statewide dental health status database.

Progress Report: During FY99, statewide dental health status data were collected for 3,502 Medicaid and 10,319 non-Medicaid indigent children. Cross checks of data were made and errors corrected.

08

Type: Risk Factor

Population: Children

The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Action Plan

1. Activity: Provide high-quality safety seats and education concerning their use to low-income families through a loaner program or free of charge [seats will be provided for children from ages birth to about age 6].

Progress Report: Title V purchased 7,408 safety seats which were distributed to community programs statewide. Additionally, program staff:

- C Conducted 8 National Highway Traffic Safety Administration's training classes for child passenger safety technicians; conducted 69 child passenger safety seat check-ups.
- C Distributed 500,228 educational materials.
- C Responded to 15,076 technical phone calls on the use of safety seats.
- C Wrote and distributed 3 news releases and 3 articles were published in TDH publications.
- C Developed a new video on child safety seats.
- C Developed and distributed 2 new child passenger brochures (one in English and one in Spanish)

2. Activity: Provide high-quality and attractive bicycle helmets and education concerning their use to children ages 5-14 in low-income families free of charge. Also provide incentives for their use.

Progress Report: Title V purchased 11,250 bicycle helmets which were distributed to low-income families statewide. TDH regional public health promotion specialists and Texas Department of Public Safety education officers coordinated the distribution of helmets and education.

3. Activity: Provide traffic-safety presentations to children ages 3 - 14.

Progress Report: 285 educational presentations were made to 12,207 individuals. During presentations and distributions of safety seats and bicycle helmets, pre- and post-observational surveys were conducted. Additionally, traffic safety presentations are evaluated by participants. Through the years, information and data collected showed an increase in use. For instance, in one community bicycle helmet use increased from 5% in FY 97 to 42% in FY 99.

09**Type:** Risk Factor

Percentage of mothers who breastfeed their infants at hospital discharge.

Population: Women & Infants

Action Plan

1. Activity: Investigate avenues available at TDH for tracking breastfeeding mothers in order to measure rates at discharge, 6 months, and 12 months.

Progress Report: Meetings were conducted with TDH surveillance systems contacts and work continues in order to establish baseline breastfeeding data.

2. Activity: Offer comprehensive breastfeeding promotion and management training to Title V maternity and child health providers.

Progress Report: Twenty-five training sessions were held. Of the 1110 participants who completed the training, 696 were nurses, 21 were physicians, 48 were dietitians, and 345 were in other health care fields. Utilization of a pre- and post-testing evaluation form was replaced with a "homework" form for each participant to take home, complete, and return to the training coordinator. Following the trainee's evaluation of the training, each was given a certificate of attendance and a lapel pin. By this method of documentation, an accurate count of participants was maintained and participant assessment of the training was obtained. The training evaluations showed very positive results. Comments from the evaluations will be considered when the training is updated.

Ross laboratory statistics from the "Mother's Survey, Ross Products Division, Abbott Laboratories" were used to assess the impact of the training. Statistical information statewide (county-wide statistics were not available for interpretation) confirmed the expectation that the numbers of mothers who breastfed at hospital discharge and at age 6 months would increase from the previous year. The statistics showed an increase of 2.6% in breastfeeding rates at hospital discharge and a 2.8% increase at 6 months of age.

3. Activity: Expand current provider hotline capabilities to include concerns of breastfeeding mothers.

Progress Report: This activity was completed. The plan to conduct a random sampling of callers to the hotline and to develop a system of mystery callers was re-evaluated due to time and staff considerations. An alternate plan to monitor hotline information being given to callers was implemented. Random calls to the hotline were conducted by designated state staff. Assessment of the calls to the breastfeeding hotline indicated that the information being given to callers was accurate and that the most current information available.

4. Activity: Work with the Take Time For Kids (TTFK) initiative to include educational materials about the benefits of breastfeeding.

Progress Report: This activity was completed through funding and support by Title V. Existing breastfeeding materials were sent to the Take Time for Kids (TTFK) coalitions. These coalitions work with pregnant women in the communities to increase their knowledge of the benefits of breastfeeding to the infant and beyond. The TTFK coalitions have reported using the breastfeeding materials, but the benefits of the materials have not been established by the use of a survey tool at this time. The plan to use a survey tool has been extended to the following fiscal year.

5. Activity: Encourage Texas hospitals and birthing centers to become accredited through the Breastfeeding Friendly Hospital Initiative or the Texas Breastfeeding Initiative.

Progress Report: The Texas Hospital Association endorsed the Texas Ten Steps Program. With the THA endorsement, associated hospitals are encouraged to join the Texas Ten Steps Program. Five hundred hospitals that provide maternity services were sent letters with model policies, an application, and information about breastfeeding promotion. At fiscal year end, three hospitals received designations, with five more pending.

6. Activity: Conduct an awareness campaign for health care providers (doctors, nurses and midwives) to introduce the WHO/UNICEF "10 Steps to Successful Breastfeeding."

Progress Report: Five hundred hospital packets were completed and mailed. About 1,000 community packets and 9,000 physician packets will be mailed in FY 2000. (Refer to the Activity # 2 above for the numbers of breastfeeding training sessions)

7. Activity: Develop a media awareness campaign targeting populations which demonstrated no change of behavior toward breastfeeding during FY98 breastfeeding promotion efforts.

Progress Report: The media awareness campaign composed of public service announcements (PSAs) was completed. General public surveys were completed with positive results.

10**Type:** Risk Factor

Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Population: Women & Infants**Action Plan**

1. **Activity:** Contact birthing hospitals by letter to find those interested in working with the Sounds of Texas Project to set up a universal hearing screening program in their facility.
Progress Report: Letters were sent to 281 birthing facilities, with replies coming from 150 facilities. About 70,000 newborns are being screened in a total of 30 facilities that have participated since 1997.

2. **Activity:** Conduct presentations and environmental assessments for interested hospitals.
Progress Report: The following are some of the products which will be used for this program: an environmental assessment and hospital information notebook, a website at <www.IHEAR.org>, handouts for Lamaze instructors, a parent information pamphlet in Spanish and English; and a pediatrician pamphlet. The parent brochure consists of information about the new newborn hearing screening program and state agency referral sources, if needed, and a hearing checklist. On the other hand, the pediatrician brochure includes information on the new state law and its impact on physicians. Eighty presentations and 40 environmental assessments were completed.

3. **Activity:** Train hospital staff to conduct hearing screening and to use patient management software.
Progress Report: Staff conducted site visits and telephone conversations with 150 of 259 birthing facilities regarding implementation of new programs. Staff provided training at 12 birthing facilities. Forty hospital staff were trained and 38,764 newborns were screened.

Infrastructure Building Services**11****Type:** Capacity

Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Population: CSHCN**Action Plan**

1. **Activity:** Provide case management services to assist CSHCN in obtaining a source of insurance.

Progress Report: Case management services were provided by TDH regional staff or contractors to approximately 68,000 Texas CSHCN, who may or may not have been enrolled in the Chronically Ill and Disabled Children's (CIDC) program. During FY99, case management services were also provided to CSHCN enrolled in Medicaid. Review of insurance resources is part of the case management assessment and planning process. There is no income eligibility for this case management program, although it primarily serves those under 200% of FPL.

2. Activity: Continue to refer CIDC clients up to 18 years old and 185% of the federal poverty level and/or who have reached an expenditure level of \$2,000 or more to the Medicaid/Medically Needy Program (MNP) to ensure that CSHCN receive specialty and subspecialty services, including care coordination, outside of program scope.

Progress Report: The following data pertain to clients who were referred to Medicaid and/or the Medically Needy Program due to possible Medicaid eligibility:

C	Clients referred:	4,157
C	Clients responding:	3,630
C	Clients receiving Medicaid:	871 (24% of 3,630)

12

Type: Process

Population: Children

Percent of children without health insurance.

Action Plan

1. Activity: Monitor and report the percentage of children without health insurance.

Progress Report: In FY 98, there were approximately 1.4 million or 25.4% of the total children without insurance. Data are not available for FY 99.

2. Activity: Participate in development of the Texas Title XXI Children's Health Insurance Plan.

Progress Report: The CHIP Phase I plan, a Medicaid expansion for 15- to 18-year-olds up to 100% FPL, was approved by HCFA. Total CHIP Phase I enrollment in FY99 was 50,878 children and youth. [Data from *State Children's Health Insurance Program Aggregate Enrollment Statistics for FY1999, Texas*, found at <www.hcfa.gov/init/children.htm>.]

In May 2000 the Children's Health Insurance Program (Senate Bill 445, 76th Texas Legislature; also known as CHIP Phase II) expands coverage for children and youth, ages 0-18, up to 200% FPL. CHIP Phase II was submitted to HCFA for approval.

Senate Bill 374, 76th Texas Legislature, required the Title V CSHCN program to provide a comprehensive health benefit plan similar to CHIP for children and youth who are not eligible for CHIP or Medicaid. In order to do that, the CSHCN program must be revised to remove the asset test and categorical eligibility and to add family support services. The revised CSHCN program must be implemented by 7/1/2001.

Title V staff began meeting with CHIP staff (at TDH and at the Health and Human Services Commission) to plan CHIP Phase II program implementation. Plans for redevelopment of the CSHCN program are underway.

13	Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.
Type: Process	
Population: Children	

Action Plan

- Activity: Monitor and report the ratio of Medicaid child recipients who receive a Medicaid service compared to the population of all children who are potentially Medicaid eligible.

Progress Report: In FY 99, 1,521,177 children were potentially eligible for Medicaid. Of those, 678,434 (44.6%) received a service paid by Medicaid program

14	The degree to which the State assures family participation in program and policy activities in the State CSHCN program.
Type: Process	
Population: CSHCN	

Action Plan

- Activity: Contact with a minimum of two parents with CSHCN to consult in developing and implementing a plan to enhance parent participation in program and policy activities.

Progress Report: The CSHCN advisory committee formed a subcommittee to develop a mechanism to assure family participation in program and policy activities. Recommendations included beginning with a parent under contract at

the TDH central office to study and make recommendations. A parent assumed this position in January 2000. Immediate activities include: 1) inputting to the FY2001 request for proposal; 2) attending meetings related to redevelopment; and 3) assisting in planning the National Center Cultural Competency site visit in February 2000.

2. Activity: Enhance TDH capacity to create family-centered program policies and services.

Progress Report: Initial plans were developed to include families in the restructuring of the Chronically Ill and Disabled Children's (CIDC) Program, as required by state legislation. Additionally, TDH staff collaborated with the Texas Council on Developmental Disabilities and the Health and Human Services Commission to convene three "Families Are Valued" permanency planning project sites in August 1999. The sites were in El Paso, Amarillo, and Austin. Community participants (40-60 per workshop) included parents of and providers for CSHCN. One purpose of the workshops was to gather needs assessment data and to seek guidance from parents and providers as TDH began planning for redevelopment of the CIDC program. Each site worked through a series of questions to identify strengths, gaps, and barriers in service systems for CSHCN.

3. Activity: Enhance the existing Title V information and referral system for CSHCN.

Progress Report: The new Iris software package was installed and the BabyLove Information and Referral Line received more than 4,800 calls about Title V, WIC, and Medicaid programs during FY 1999.

15

Percent of very low birth weight (VLBW) live births.

Type: Risk Factor

Population: Women & Infants

Action Plan

1. Activity: Review existing trends of identified factors contributing to very low birth weight live births and determine geographic areas and sub-populations at risk.

Progress Report: In 1998 reports provided by TDH's Research and Public Health Assessment Division, 1.3% of all live births in Texas were Very Low Birth Weight Live Births (VLBW). This represents an increase of 8.3% from 1994 and is primarily due to the increase multiple births. VLBW singleton births did not increase from 1994 to 1998. Identified factors for VLBW's include black mothers, the youngest and oldest mothers, and geographic areas of Texas, which include PHR 1 at 4.8%, PHR 2 at 4.0%, PHR 8 at 3.1%, and PHR 9 at 4.3%. Based on identified geographical area and subpopulations at risk for VLBW live births, a plan was developed to provide written materials in brochure

form, which explained the possible causes, intervention and prevention of factors contributing to VLBW live births. Implementation of the plan is planned for FY2001.

2. Activity: Increase contractors' awareness of available educational materials that target the high risk factors of pregnancy contributing to very low birth weight live births (VLBW's).

Progress Report: Meetings were held with TDH marketing and outreach/public health education and promotion staffs to begin the development of educational materials for contractor distribution to their clients at risk for VLBW live births. Due to staffing constraints, this activity was not completed. Plans are underway to re-institute this activity the next fiscal year.

16

Type: Risk Factor

Population: Children

The rate (per 100,000) of suicide deaths among youths aged 15-19.

Action Plan

1. Activity: Evaluate the effectiveness of the "Mental Health CPR" videotape in teaching teens to recognize signs of impending suicide in their peers and how to get preventive help.

Progress Report: Analysis was conducted and a five-page report on the "Mental Health CPR" videotape was produced by TDH staff. The sample for analysis consisted of 840 students from Texas schools, with 48.5% responding from urban areas and 51.5% from rural areas. The subjects for the study ranged in age from 11 years old to 20 years old, with a mean age of 15.3. The students experienced an increase in knowledge and skill about suicide intervention and an increase in behavioral intent to help prevent peer suicide after viewing the video. After review of this evaluation, staff agreed to supply the video along with curricula and handouts to assist trainers in presentation.

2. Activity: Make the final videotape available to schools and programs serving teens and target distribution to areas with elevated teen suicide rates.

Progress Report: Reproduction of 120 videos was completed in the fall of 1999. There was concern about just sending the curriculum and videos to schools without instituting some way to determine how the product would be used. Therefore, a cooperative agreement was established that the school health specialists in each of the 20 Education Service Centers would act as facilitators for the project. Fund implementation is still in progress.

17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
Type: Risk Factor
Population: Women & Infants

Action Plan

1. Activity: Implement rules establishing a statewide voluntary perinatal care system pursuant to Senate Bill 1229 to provide a medical home to all perinatal patients.

Progress Report: Rules were developed by TDH staff and approved by the Board of Health in July 99. Implementation will begin in FY01.

18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
Type: Risk Factor
Population: Children

Action Plan

1. Activity: Review existing trends on entry into prenatal care by gestational age and determine areas and sub-populations with late entry into prenatal care.

Progress Report: In reports provided by TDH's Research and Public Health Assessment Division, statistics identify 79.3% of all live births in Texas were to women who began prenatal care during the first trimester of pregnancy. In 1998, 18.7% of all live births were to women with late entry into prenatal and 2% of all live births were to women who received no prenatal care throughout their pregnancy. The percentage of births to women with onset of prenatal care within the first trimester increased in Texas and nationally from 1994 to 1998. However, the percent in Texas is consistently lower than the national average. Targeted interventions to reach women not yet pregnant or pregnant women still in their first trimester of pregnancy, especially African American, Hispanic women and pregnant adolescents aged 10-14 years, are planned for the next fiscal year.

State Performance Measures

Direct Health Services

01

Type: Risk Factor

The rate (per 10,000) of genetic services utilization

Population: All Title V Populations

among women and children in Texas.

Goal: To improve genetic referrals

Action Plan

1. Activity: Conduct a literature review and compile a list of effective genetic education programs.

Progress Report: Out of the 25 programs identified, the effectiveness (based on the general genetic information offered to a wide audience with increased understanding by all participants) of two appeared to meet the program's outcome expectations. The next step was to develop and pilot a web page for information on genetic services, providers, and other resources. The pilot's results will be included in FY 2000 report.

2. Activity: Share the list of effective programs with genetic providers and TEXGENE to select the most viable programs for potential implementation.

Progress Reports: Among the five program identified, three are still to be evaluated by TDH staff.

3. Activity: Develop a plan for implementation of a statewide genetic education program for providers of health and education services.

Progress Report: Plan development continues. Limitations include the lack of cooperation from local entities for the first steps of implementation dealing with logistics, such as finding a training facilities. On the other hand, three universities receiving Title V funding are currently working with TDH on the following projects:

- C Baylor College of Medicine in Houston — a private entity: this project includes a one-day genetics training program for health care professionals to recognize genetic diseases in all age groups.
- C University of Houston — a public entity: this project offers a one-day training to non-geneticist professionals (nurses, counselors, and educators) helping them recognize genetic diseases in school age children.
- C University of Texas Health Science Center at San Antonio — a public entity: provides a one-on-one training for physicians to increase their awareness about genetic disorders so that appropriate referrals for genetic services can

be made.

02

Type: Process

Population: Children

The percent of well child visits by Title V funded agencies.

Goal: To ensure better usage of preventive health care services for children

Action Plan

1. Activity: Develop/review information for parents to inform them of the need for preventive child health care and explore creation of a parent package for distribution to parents; and survey providers and parents receiving Title V services.

Progress Report: The program continues to support national guidelines for preventive health care. "Bright Futures," etc. are referenced in state child health guidelines provided to all Title V contractors. Program staff coordinate these standards with the EPSDT program requirements. Staff began developing health risk profiles for use with the 0 - 21 year population; these are also based on TDH guidelines. However, a questionnaire was not developed due to other activity priorities.

2. Activity: Develop the "Pediatric Putting Prevention Into Practice" (PPPIP) module, and provide training on the use and benefits of the module to Title V providers and other interested health care providers.

Progress Report: The module draft was completed, but the decision was made that other TDH programs provided greater guidance for practitioners. TDH promotes "Bright Futures" which is very similar to PPPIP and from which "well child standards" for Title V and Medicaid were developed.

3. Activity: Develop preventive care educational materials for regional school health education specialists in order to provide resource material for school nurses and school-based clinics.

Progress Report: TDH staff, with the collaboration of the school nurse liaison, developed the "Delegation of Health Services in Texas Public Schools" document to assist school administrators and school health services staff understand lines of communication and authority.

Other materials distributed to Texas' 20 regional Education Service Centers and school-based health centers addressed the following issues: abstinence education, tobacco prevention, substance abuse prevention, nutrition, physical activity, violence prevention. In total, materials were distributed to 112,077 education and healthcare professionals.

Population-based Services

03 The rate (per 1,000) of elevated blood lead levels
Type: Risk Factor among Medicaid-eligible children up to age 6.
Population: Children

Goal: To ensure better access to needed services for children with elevated blood lead levels

Action Plan

1. Activity: Train TDH regional lead poisoning prevention teams on the triage system which is designed to identify the type and level of interventions needed for children with elevated blood lead levels.

Progress Report: TDH staff presented a CLPPP workshop for triage system training in Houston in April 1999. Approximately 100 regional and city/county health department staff and private providers attended. Additionally, Houston regional staff participated in a Continuous Quality Improvement team that researched the follow-up problems for children with elevated lead levels and planned improvements. All other regions received triage training during FY97 and FY98, and the remaining region, Public Health Region 4/5N, received training in September 1999. Training activities continue as needed.

2. Activity: Promote awareness of lead poisoning risks and interventions by sending the "Get the Lead Out" manual to all new Title V and Medicaid providers, and survey providers in areas of high lead incidence.

Progress Report: Approximately 1,000 manuals were provided to the TDH Laboratory to be included with lab supplies mailed to new Texas Health Steps (formerly EPSDT) and Title V providers. On request, an additional 600 were sent by the Childhood Lead Poisoning Prevention Program (CLPPP) to providers and to other interested groups and individuals, including regional and local health department staffs who also distribute the literature to providers in their areas.

Efforts are ongoing to complete a three-year data summary report of Texas Health Steps' blood lead screening levels and to identify areas of high lead incidence. Since this report was expected to be completed March 2000, requests from providers in specific areas were not measured during FY99.

The following CLPPPs were established in Texas urban areas where many cases of lead poisoning occur: Houston, Harris County, Dallas, San Antonio, and Austin. These programs also promote awareness of lead poisoning risks and interventions in their areas.

3. Activity: Send notification letters to both providers and parents of children with lead levels of 20 ug/dL and greater.

Progress Report: 901 letters of notification were sent to parents in FY99.

The CLPPP mails letters on a weekly basis to Medicaid and Title V providers with children identified as having an initial blood level of 20 micrograms per deciliter (ug/dL) or higher. The letters include a questionnaire for providers to complete and return to the CLPPP whenever follow-up information is available. Follow-up information is then entered into TDH's Lead Tracking Database, and letters are sent to the contributing providers to inform them that CLPPP provides educational materials for clients and medical staff and to explain the process of requesting an environmental investigation.

Parent and provider letters are generated simultaneously. Parent letters, sent by certified mail, notify the family that a high lead level was detected and encourage them to return to the child's provider for appropriate follow-up. Pamphlets about childhood lead poisoning are included with the letter. For the small percentage of children for whom mailing addresses are unknown, a parent letter and envelope are included in the provider letter with a request that the provider send these to the parents; it is possible to determine compliance with this request at this time. Fewer than 10% of the certified letters are returned to the CLPPP unclaimed or undeliverable. A copy of those are sent to the appropriate regional lead contacts, so they may make subsequent attempts to contact the family and ensure the child is receiving follow-up.

Due to ongoing efforts to complete the three-year summary of data for elevated lead levels among Texas Health Steps and Title V children, changes in the percentage of children with elevated lead levels by zip code have not been evaluated by the CLPPP. The summary report for 1997-1999 is expected to be completed in March 2000.

Infrastructure Building Services

04

Type: Capacity

Population: Children

Percent of school-age children receiving oral health education.

Goal: To increase community awareness of oral health, dental disease and the benefits of prevention

Action Plan

1. Activity: Develop a needs assessment questionnaire for 3rd grade students to survey existing knowledge levels and behaviors of oral health practices.

Progress Report: The Division of Oral Health via regional staff has provided oral health education through the "Tattletooth" and "Take Time for teeth" program. Other program priorities were emphasized, to the extent that the evaluation phase has not been completed.

2. Activity: Develop a needs assessment tool to survey school administrators and teachers about existing oral health education programs and categorize schools by types of programs used.

Progress Report: The Division of Oral Health did not assess the effectiveness of oral health education programs during FY99.

3. Activity: Initiate the development of new educational materials and audiovisuals for educators in school districts statewide .

Progress Report: The Division of Oral Health did not assess the effectiveness of oral health education programs during 1999. Other program priorities delayed the evaluation phase

05

Prevalence of carious lesions in school-age children.

Type: Capacity

Population: Children

Goal: To establish an oral health data resource center

Action Plan

1. Activity: Establish a workgroup to develop and pilot a measurement tool to determine children's dental health status.

Progress Report: In FY 99, the Division of Oral Health conducted dental examinations on school children on the "Free Lunch program."

The program will expand examinations to include the extra school population, therefore, obtaining a more accurate baseline data for the school children, regardless of socio-economic status.

The current scheme of operation is a three year cycle of visits to school campuses. The modification to the program will produce a valid and reliable sample.

06**Type:** Capacity
Population: CSHCN

Percent of preterm and/or low birth weight infants receiving a nutritional assessment.

Goal: To improve access to quality nutrition services for CSHCN by developing and conducting training workshops for licensed and registered dietitians**Action Plan**

1. Activity: Develop a training curriculum for licensed and registered dietitians on nutrition care of premature and/or low birth weight infants and conduct statewide workshops for Title V providers, including WIC dietitians.

Progress Report: The development of the training curricula on nutrition care of premature and/or low birth weight infants was delayed due to several factors:(1) only a 50% CSHCN nutrition consultant was assigned to this project; (2) this CSHCN nutrition consultant is funded by WIC and the updating and training of WIC staff on WIC formula policies was placed as a higher priority by the Division Director than development of the premature/low birth weight infant nutrition module. Formulas for premature infants is just one part of all of the WIC formulas. This area has needed constant attention, as new infant formulas are continuously being marketed and ordered by physicians for WIC infants.

2. Activity: Develop a nutritional counseling methodology and survey tool to conduct follow-up assessments on growth and other nutritional status parameters for premature and/or low birth weight infants.

Progress Report: No progress was made on this activity due to staffing constraints. This performance measure and activity have since been deleted from the State Performance Measures.

07**Type:** Capacity
Population: CSHCN

Percent of children with special health care needs receiving high quality health care and health related services.

Goal: To provide access to high quality health care and health related services to CSHCN regardless of funding source or type of service delivery system.**Action Plan**

1. Activity: Develop or adopt a methodology and valid tools for measuring the quality of health services and customers satisfaction with those services.

Progress Report: A tool was developed for the Medically Dependent Children Program, a 1915c waiver program. The development took place over about a year's time, and data have been collected for a full year from the pilot site with University of Texas Health Sciences Center in San Antonio.

The tool was designed with dual purposes: (1) to identify issues, areas, and opportunities for program improvement based on input from recipient families and (2) to determine whether family choice (regarding providers and services) would positively correlate with overall family satisfaction with services. Early analysis indicates a positive correlation between choice and satisfaction. The program also identified areas to target for improvement, which include: (1) better information for families, (2) permanency planning, and (3) suggestions for improving the tool itself. Appropriate changes will be made to the tool, and it will be distributed for another full year. The results will be analyzed and compared with the first year's results.

08**Type:** Capacity**Population:** Women & adolescents

Percent of clients suspected of being victims of relationship abuse.

Goal: To increase detection of and appropriate responses to women and adolescents seeking health services who are suspected victims of relationship abuse

Action Plan

1. Activity: Develop and implement a data collection system to track the number of suspected victims of abuse and number and types of referrals made by health care providers who received training on abuse prevention.

Progress Report: A data collection system was developed. Implementation was delayed by Rider 18 to the Texas Appropriations Act. A key component of the data collection tool is child abuse reporting. Recent changes in Texas Family Code and specifications of Rider 18 created policy questions that will not be answered until after the rules for Rider 18 are published. Until that time, all materials and information about child abuse reporting have been put on hold.

2. Activity: Distribute statewide the model policy and procedure for victims of family violence through Title V providers and other interested health care providers. The model policy manual addresses the issue of mandatory reporting and recommends assessment, treatment and referral options.

Progress Report: A policy and procedure model for victims of family violence was updated and distributed to all family planning providers in September 1999. Plans to assess the impact of the manual are scheduled for FY01 but remain on hold due to activities associated with Rider 18 (see report for Activity 1 above).

Until the policy issues relating to Rider 18 are resolved, all materials and information about child abuse reporting have been suspended.

3. Activity: Provide abuse prevention training to Title V providers and other interested health care providers in collaboration with different state agencies and organizations (i.e., Texas Council for Family Violence and Texas Association Against Sexual Assault).

Progress Report: Abuse prevention training was provided to 17 family planning contractors and 16 other health care provider groups. TDH worked in collaboration with several other state agencies and organizations. Until such time as policy issues relating to Rider 18 are resolved, all materials and information about child abuse reporting have been suspended.

4. Activity: Enable TDH regional offices to take the lead in conducting community/local awareness campaigns among population groups at high risk for abuse.

Progress Report: This activity was delayed due to the impact of Rider 18. Until such time as policy issues relating to Rider 18 are resolved, all materials and information about child abuse reporting have been suspended.

Progress on Performance Measures

National Performance Measures

The following is a rough assessment of the status of FY 99 annual performance objectives. Whenever possible FY 99 data have been obtained for this report. Some FY 99 preliminary vital statistics data are not available and estimates are not provided, as we agreed with MCHB. However, when FY 99 data were not available, FY 98 data represent the current status of program performance. Because of significant factors beyond the control of Texas Title V program and the difficulty in proving cause and effect relationships in these settings, it is premature to link any increase or decrease in measurement with the activity plans' completion.

Texas remained consistently on target in FY 99 with 50% of SSI beneficiaries younger than 16 (23,889 youngsters) receiving rehabilitative services from the CSHCN program. In FY 99 the performance measure target changed from 60% to 50% because of more accurate data collection methods.

FY 99 data indicate that 21.4% of CSHCN, 211,369, were identified as having a "medical/health home." While this figure consistently remained slightly below the objective each year, it increased progressively on an annual basis.

Continual and expanded efforts to assure aggressive case management of identified presumptive positive cases and to increase parents' awareness of the legal requirement for newborn screening helped TDH to exceed its FY 99 performance objective of 97.4% newborns having at least one screening for each PKU, hypothyroidism, galactosemia, and hemoglobin-

pathies. The annual performance indicator shows that 97.7% of newborns in the state (350,418) received at least one screening

Data show that 72.4% of children through age two completed immunization shots in the FY 99. The promotion of "My Child's Health Record" may have helped in achieving this performance indicator.

Major success in reducing the rate of births (per 1,000) for teenagers aged 15 to 17 years may be due to the integration of the "It Takes Two" program in a number of Texas communities. This program includes an innovative educational curriculum that encourages young men and women (ages 12-19) to view pregnancy prevention as a shared responsibility by illustrating the consequences of premature and unprotected sexual activity, hopefully motivating them to make responsible decisions about sex, and modeling healthy, respectful, and safe male/female relationships. Data show a decrease in teen pregnancy from a rate of 48.9 in FY 96 to 47.4 in FY 98. The FY 98 performance objective set for this measure is 50.

Data reveal that the FY 99 performance objective of 17% for third-grade children receiving sealants was exceeded, with 19.7% or 642 receiving sealants. However, it should be noted that data are limited, because the denominator includes only children in the Free Lunch program.

In FY 99 approximately 45,000 newborns were screened prior to hospital discharge in a pilot program to identify hearing impairment. These screenings accounted for 12.8% of the total population of occurrent births and fell short of the 30% target. Statewide mandatory testing begins late in 2000, after which time baseline figures can be obtained.

FY 98 data indicate that 75.5% of the CSHCN in the state CSHCN program had a source of health insurance for primary and speciality care. This figure was below the 79% target.

In FY 99, 1,521,177 children were potentially eligible for Medicaid. Of those, 678,434 (44.6%) received a service paid by Medicaid program. The FY 99 performance objective indicates a target of 48%.

Many efforts are needed in pre-pregnancy planning to provide the best opportunity for positively affecting pregnancy outcomes, including reduction of VLBW live births, and in identifying key reasons why the percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates is decreasing. While the percent of VLBW live births remained consistent in FY 98 at 1.3%, that figure was below the 1% target. On the other hand, the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates, was below its 55% projection at 52.9%.

A significant decrease in the number of suicide deaths among youths ages 15-19 was witnessed in FY 98. Data indicate an improvement from a rate of 12.1 in FY 97 to 9.8 in FY 98. The FY 98 performance objective target was 11.5.

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester still remains a challenge for Texas. While the FY 98 performance indicator shows

that 77.8% of this population receive prenatal care in the first trimester, the corresponding performance objective's target is set at 81%.

State Performance Measures

The increased educational activities and outreach efforts of the TDH Genetics Division staff led to an increase in the performance indicator utilization rate from 22.4 in FY 97 to 37.9 in FY 99. This exceeds the FY 99 performance objective target of 27.

With 21.1% (80,868) of the state's children being considered obese in FY 99, Texas fell short of achieving its objective of 20%.

Although the state goal for lowering the rate of elevated blood lead levels was set at 50% from FY 96 through FY 99, marked reduction in the rate occurred in FY 98 (45.4 per 1,000) and again in FY 99 (37.3 per 1,000). This rate reduction may be associated with (1) widespread training of health care providers and TDH regional staffs in a triage system to identify the type and levels of intervention needed for children with elevated blood lead levels, (2) distribution of intervention manuals, "Getting the Lead Out," to all new EPSDT and Title V providers, and (3) TDH mailing of parental notices relative to children with high blood lead levels.

At 8.6 per 10,000 live births, the prevalence rate for neural tube defects-affected babies dropped below the 10 per 10,000 live births goal in FY 98.

Well-child visits provided by Title V-funded contractors decreased slightly to 43.8% or 26,736 visits in FY 99. The target was 50%.

The rate of women and children utilizing genetic services increased dramatically to 37.9/10,000. This number exceeded the previous year's rate of 28.3/ 10,000 and the FY 99 goal of 27/10,000.

In FY 99 the percentage of female clients suspected of being victims of relationship violence remained constant, meeting the target of 3.9%.

The FY 99 data for percentage of carious lesions among third- through seventh-grade children was notably higher than our predicted target of 43% at 50.9%. However, the population from which the data were extracted is the Free Lunch program. TDH plans to change the sample size to be more representative of the total statewide population and not to be restricted to the free-lunch population.

2.5 Progress on Outcome Measures

Texas is making steady progress in reducing infant, neonatal, postneonatal, and perinatal mortality rates, as well as the overall child death rate. See Supporting Documents, Form 12, for trend data for 1996-2001. In estimates of its FY98 data, Texas exceeds most of the *Healthy People 2000* Objectives for these outcome measures. However, the state's indicators

are larger than those of the national objectives in the ratio of black-to-white infant mortality rates, even though the Texas infant mortality rates for blacks and for whites exceed the national objectives. The Texas Title V program is making good-faith efforts to meet this objective by 2000; Texas projections show continued decreases in the black and white infant mortality rates, but the ratio is still predicted to be slightly larger than the *Healthy People 2000* Objective.

Healthy People 2000 points out that the most effective community-based health promotion programs “recognize the inter-relationships between behavior and the environment and include multiple interventions directed at multiple levels (e.g., individuals, small groups/families, organizations, community.” To that end, Texas continues to address the leading causes of postneonatal and perinatal mortality by: (1) increasing public awareness of SIDS and congenital anomalies, (2) developing and continuing strategies to reduce the occurrence of injuries and infections that are amenable to prevention, (3) implementing a voluntary perinatal care system to link networks of health care facilities around the issues of perinatal care, and (4) promoting client and provider awareness of the benefits of pre-pregnancy counseling and first-trimester prenatal care.

Reducing racial differences in pregnancy outcomes is a Texas priority. African-American women who are experiencing prematurity, low birth weight, and infant and fetal death will be targeted through Texas Department of Health offerings to promote effective pregnancy planning. The Texas Title V program has been involved in several activities to improve these outcomes measures and those of other at-risk clients.

In 1995 the Texas Legislature mandated implementation of a statewide prenatal care public awareness campaign designed to impact the infant, neonatal, postneonatal, and perinatal mortality rates through passage of Rider 45 of the 1996-1997 Appropriations Act. Despite being temporarily put on hold due to staffing changes, aims of the awareness campaign were furthered by certain strategies: (1) regional and central office staffs promoted the benefits of pre-pregnancy counseling and first-trimester prenatal care through widespread public dissemination of information on the topics, and (2) WIC, family planning, and maternal and child health clinics continued to provide timely and appropriate health education to clients and visitors. There is still a need for a prenatal care awareness campaign that targets high-risk clients (e.g., African-American, very young, and older women of child-bearing age) and providers who serve those populations. As TDH women’s health care staffing stabilizes, this plan will be reactivated along with emphasis on individualized client education to improve birth outcomes.

The *Healthy People 2000* section on maternal and child health reports that low birth weight and infant death related to unintended pregnancy could be addressed by providing accurate information about human sexuality to sexually active people, by facilitating behavior changes relative to the information learned, and by providing convenient, local family planning services and information. Recent cuts in federal funding for these programs prevented training in a male-female teen education project, and the current trend to promote programs that focus on singular causal relationships greatly limits the capability of TDH’s Family Planning Program to address unintended pregnancy, especially among teenagers. However, two male-involvement pilot projects were initiated in Houston and in Austin, and implementation of a third project is

planned for FY00.

The decline in infant mortality is largely attributable to advances in neonatal care and the dissemination of information about those advances throughout neonatal care units nationwide. Acknowledging this fact, the Legislature, in 1995, mandated the development of standards and objectives to establish a statewide network of voluntary perinatal health care systems as directed by House Bill 2212. Extensive work went into the collaborative writing of rules for that law. Since this was to be a voluntary program, emphasis was placed on community-based support and services delivery. As a result, public input was solicited numerous times from hospital districts, medical schools, and other entities contributing to the perinatal care systems to assure a good fit between TDH's system development processes and local providers needs. The rules to initiate this network were proposed to the Board of Health in FY98 and enacted during FY99 when TDH staff met to address the provisions of the rules relative Senate Bill 1229's mandate to provide a medical home to all perinatal patients.

Texas continues to design and implement programs to get more young children into medical homes for preventive and primary health care. In 1997, House Bill 997 established a pilot project for primary care health insurance coverage of children younger than 13 years of age and ineligible for Medicaid. This model, initiated in a Laredo elementary school, made comprehensive health care available through the local public school; was patterned after Florida Healthy Kids; and collects co-pays and sliding scale premiums. Cost for this health care was affordable at \$45 per month, and the project provided access to a local network of health care professionals and hospitals.

In order to provide more comprehensive health care coverage for women and children across the state, Texas' Medicaid managed care program added the Harris County service area with its seven new contractors to the five existing service provision areas and their 15 contractors. The Dallas rollout of Medicaid Managed Care is in progress. Complementary Title V case management services to an estimated 47,299 CSHCN clients by regional staffs and 14,814 by 21 case management contractors in FY98 serve to facilitate linkage into and across the various funding sources for greater access to and flexibility of care.

Other efforts to reduce deaths from the neonatal period through early childhood include Texas' implementation of universal HIV screening of pregnant women, with follow-up procedure of administering AZT for positives. In order to assure case management and linkage with appropriate care for 100% of the presumptive positives found by the Newborn Screening (NBS) Program, the program is researching software programs that are more efficient and interactive than the current system. In addition, NBS is expanding their outreach regarding benefits and legal requirements of screening through statewide distribution of standardized literature available in English and in Spanish, and dissemination data are being measured against FY98 birth data (i.e., registered births compared with newborn screens). The literature distribution network includes Texas obstetricians, WIC administrative sites, website publication, and NBS specimen submitters.

Additionally, since January 1995, childhood immunization rates for the 4:3:1:3 series continue to improve by at least one percent every year, thereby reducing the likelihood of childhood mortality to complications associated with diseases like pertussis, diphtheria, polio, and

influenza. More than half of local health departments used ImmTrac, and virtually all contractors comply with state immunization policies. Hepatitis B immunizations in the four model urban areas — Bexar, Dallas, and El Paso Counties, and Houston — have been maintained at 82%, contributing to lowered child mortality rates in areas where Hepatitis B is more likely to be transmitted on a widespread scale. Although the costliness of these immunizations prohibits their statewide administration at the present time, expanded service areas will greatly improve state childhood mortality outcomes resulting from loss of liver function.

“Mental Health CPR,” a videotape teaching teenage responsibility for personal actions, was evaluated for possible dissemination in Texas schools as one means of addressing the teen suicide rate in Texas. Students in the pilot increased knowledge, skill, and intent to intervene relative to suicide prevention; therefore, TDH staff decided to supply the video, curriculum, and handouts to trainers interested in using the videotape and to facilitate that training from Education Service Centers throughout the state. Like the work needed to reduce all childhood mortality, teenage suicide requires multiple, interdisciplinary, and cross-agency approaches to intervention in order to assure the desired outcomes of greatly reducing or even eliminating teen suicide. TDH’s hiring of an adolescent health coordinator in September 1996 is facilitating program development along those lines.

Texas’ Neural Tube Defects (NTD) Project, involving health professionals and community volunteers in a 14-county area along the Texas-Mexico border, should contribute directly and in immediately measurable ways to the reduction of neonatal, perinatal, postneonatal, and infant deaths. A period of high incidence of NTDs in those counties led to the surveillance and follow-up aspects of this project — an awareness components that (1) alerts women of child-bearing age and those with past NTD deliveries about the potential for future NTDs and (2) facilitates their access to folic acid intervention services. Accompanying professional awareness activities urge neural tube/folic acid counseling for reproductive-aged women. Up to March 1997, 227 out of 301 (75%) identified women were eligible for intervention and 138 (61%) were placed on folic acid. The remaining refused enrollment, quit, or were lost to the project.

During FY99 TDH staff distributed 11,250 bicycle helmets to low-income families through community safety programs and provided free education on the proper use of bicycle helmets. Staff also purchased and distributed 7,408 safety seats to community safety programs statewide, conducted eight National Highway Traffic Safety Administration’s training classes for child passenger safety technicians and 69 child passenger safety seat check-ups. Staff distributed 500,228 educational materials, responded to 15,076 technical phone calls on the use of safety seats, wrote and distributed three news releases, published three articles in TDH publications, developed a new videotape on child safety seats, and developed and distributed two new child passenger brochures in English and in Spanish. In addition, staff conducted 285 educational presentations about bicycle helmets and safety seats to 12,207 individuals. (The motor vehicle death rate for children under 15 years of age in 1997 was 5.9 per 100,000 population, a slight decrease from the 1996 rate.)

TDH staff also monitored hospitalization patterns of injured in Texas hospitals, established Safe Kids Coalition in Rio Grande Valley, and established “Take Time for Kids” link with the

TDH Injury Program's web site.

TDH continues working to reduce the incidence of blood lead levels and to improve the follow-up process for children with elevated lead levels through its regional lead poisoning prevention teams at each TDH public health region. In FY99 TDH's Childhood Lead Poisoning Prevention Program (CLPPP) conducted triage system training in lead poisoning prevention for approximately 100 PHR 6/5S regional and city/county health department staffs and private providers, and people in PHR 4/5N, the remaining region to be trained, received training in September 1999. TDH staff provided 1,000 "Getting the Lead Out" manuals to the TDH Laboratory for distribution to new EPSDT and Title V providers, and CLPPP sent an additional 600 manuals directly to providers or to regional and local health department staffs for distribution to providers. Additionally, 901 letters notifying parents and their providers of their children's high blood lead levels were mailed in FY99, with fewer than 10 percent being undeliverable. A three-year data summary report of THSteps (EPSDT) blood lead screening levels is in progress. Additionally, new CLPPPs were established in the following at-risk urban areas: Houston, Harris County, Dallas, San Antonio, and Austin.

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

1. Process used

In 1995-1996, the Texas Department of Health initiated the Title V Futures Project to prioritize various issues regarding the health care needs of mothers and children, including children with special health care needs, and to begin to restructure the Title V program to reflect broader population-based/infrastructure building needs over specific categorical target populations. These efforts have continued with the implementation of an allocation methodology (formula) for the statewide, equitable distribution of Title funds; the implementation of a competitive application process for Title V funds allocated for the provisions of direct care, enabling, population-based, and infrastructure building services to any qualified provider; the reinforcement of Title V program as a gap-filling role only for direct health services; the ongoing monitoring of pertinent health outcomes and indicators; and several other significant projects both locally and statewide to improve the quality, quantity, and availability of information on which to base MCH/CSHCN related public policy.

2. Methods

It is important to recognize that the state population has grown by nearly 50% from 1980 to 1998 while becoming more racially and ethnically diverse and revealing health disparities within the maternal and child health population. Several methods have been used to assess the need for direct health care, enabling, population-based and infrastructure services so that intervention priorities can be established and the long- and short-term impact of health programs can be monitored. For instance, on a statewide basis, surveys have been conducted to gather data and information to assess whether selected health-risk and health-related indicators increase, decrease, or remain the same over time. On a regional and local levels, public hearings and forums have been conducted, particularly among minority populations and/or in targeted geographic areas, to discuss specific area-related topics and to assess the need for systems development.

Below are descriptions of methodologies and procedures used to assess the needs of the Title V population. The first approach consists of the monitoring and reporting of pertinent health status parameters. The second approach includes completed projects and surveys that provided valuable information in delineating program priority needs in order to improve the service delivery and health status of the Title V population. These projects and surveys were fully or partially funded through the Title V program. Brief descriptions and results of each project are listed in Section 3.2.2. under the corresponding Title V population type. In addition, references to the coordination and collaboration that took place between Title V programs and their stakeholders (i.e., public and private sector, state and local levels of government, and citizens) in the course of completing each project are made.

Health Status. The Associateship for Community Health and Resources Development and the State Title V program conduct extensive data analysis of health status parameters as part of

ongoing internal and external needs assessment activities and projects. The Associateship Research and Public Health Assessment Division collected primary and secondary health status data on women and children from multiple sources, both within and outside TDH. Data were combined, justified across sources, critically analyzed, and finally consolidated into a comprehensive statement of need for the MCH and CSHCN populations (see Appendix D). TDH data sources were: the Bureau of Vital Statistics, Bureau of State Health Data and Policy Analysis, Bureau of Nutrition Services (which includes the WIC program), Medicaid Managed Care program, Bureau of Children's Health, Bureau of Women's Health, Bureau of Community Oriented Public Health, Bureau of Chronic Disease Prevention and Control, Bureau of HIV/STD Control, Bureau of Epidemiology, Bureau of Laboratories, TDH public health regional offices, and TDH contractors of MCH and CSHCN services.

Non-TDH sources included the Health and Human Services Commission, Texas Department of Human Services, Department of Protective and Regulatory Services, 1990 U.S. Census, Texas State Board of Medical Examiners, Texas State Board of Nurse Examiners, Texas Medical Association, National Center for Health Statistics, Texas Education Agency, Texas Commission on Alcohol and Drug Abuse, Texas Interagency Council for Early Childhood Intervention (Part H agency), Texas Department of Mental Health and Mental Retardation, Head Start program, Kids Count, Texas Youth Commission, and Centers for Disease Control and Prevention.

Data collected are presented in this document by state, region, and county. Most of the needs assessment data were analyzed referencing socio-economic status, race/ethnicity, and age, and were also cross-analyzed to illustrate certain meaningful associations. In addition, data were analyzed over time so that trend information could be used to augment data about identified needs. Finally, state data are compared to available national data and the Healthy People 2010 objectives.

Since there is no operational definition for the term "children with special health care needs" and as yet there has been no census of childhood disability, Texas Title V uses proxy measures to estimate the prevalence of chronic health conditions and disabilities. Among other sources of information, projections based on results from the National Health Interview Survey (NHIS) were utilized.

3. Major steps involved in identifying program emerging issues and delineating subsequent priority needs.

In general, Title V adopts common steps involved in the planning process cycle, starting with the identification and understanding of the problem; prioritizing resulting program needs and selecting effective interventions; setting realistic objective targets; implementing, monitoring, and evaluating impact; and, as needed, making necessary re-adjustments; and finally, reinitiating the cycle based on lessons learned and best practices.

Usually there are internal and external sources available to the Title V program to identify emerging issues, barriers, and program needs. External sources include new strategic directions from the TDH Board of Health, the Texas Legislature, MCHB, and involvement and consultation with Title V stakeholders. Internal sources include ongoing review of quality

assurance reports on compliance with established policies and procedures, monitoring service utilization levels, monitoring of health status indicator trends, and program advisory committees input and recommendations. The Associateship Round Table Committee meets on a weekly basis to discuss emerging issues and to identify subsequent program needs. The Associate Commissioner chairs the committee which includes bureau chiefs, both Title V directors, and key support division directors. Based on program information and data trends, and according to priority criteria, the committee always ranks the program needs because of the overwhelming number of needs. As appropriate, the committee seeks the involvement of other state health and human agency programs in the process. The next level consists of involving program staff to delineate activity plans, assess required resources and funding, work with the Planning Unit and Research & Public Health Assessment staff to develop short- and long-term impact plans, including the setting of objective targets. Prior to sending the action plan to the Round Table Committee for review and approval, program staff seek the involvement of the program's advisory committee in the short- and long-term impact plans. In addition, program staff post the plan on the web site and mail the plan to interested Title V persons. As time allows, forums will be conducted with Title V interested parties to seek further input. Comments received are compiled and attached to the action plan for the Round Table Committee's consideration.

4. Strengths and weaknesses of current methods and procedures

The quality and integrity of results from qualitative and quantitative projects used for ongoing needs assessment activities are always useful indicators for the Title V leadership to consider ways to improve the methodologies and processes. While some projects include strong and sound methods and procedures, others need improvement. For example, forums and public hearings in some areas did not produce the expected results due to the low attendance and/or a disproportionate number of testimonies by either providers or parents. One solution to this problem would be to facilitate attendance by providing transportation and day care for target populations. Furthermore, aggressive efforts should be deployed to increase the overall response rate (27%) of the FY 1999 Youth Risk Behavior Survey (YRBS) in order to obtain results representative of Texas public high school 9-12 graders. The FY 2000 YRBS response rate is expected to be higher. Also, baseline data for some national and state performance measures are not available. In these cases, proxies representing a specific population or a limited geographic area have been used rather than the targeted population at the required statewide scope (see footnotes on Form 11). For example, the percent reported on the performance measure regarding sealants placement among third grade children includes only children in Free Lunch program. Activity plans are being developed and will be implemented during FY 2001 to determine needed health status baseline data. In contrast, needs assessment projects such as NTDs, Dental, and water fluoridation are based on reliable and valid data collection tools and sound methodologies.

Table 4

**Needs Assessment Indicators by Region/County
For Pregnant Women, Women of Childbearing Age, and Infants.**

Public Health Region	PHR 1	PHR 2	PHR 3	PHR 4	PHR 5	PHR 6	PHR 7	PHR 8	PHR 9	PHR 10	PHR 11	TEXAS
# of Women Age 15-44 (CY98)	170,629	114,077	1,178,876	204,818	154,640	1,046,313	508,304	468,085	118,340	161,752	372,329	4,498,163
# Women Eligible for Title V Age 15-44 (CY97)	54,422	36,480	245,158	60,403	44,509	247,009	138,683	144,351	36,970	62,714	147,391	1,218,090
# Live Births (CY98)	12,132	7,402	88,343	13,900	9,985	80,180	35,020	34,362	8,293	14,824	37,758	342,199
# Medicaid Deliveries (FY98)	5,594	3,894	24,539	7,403	4,968	26,925	8,314	14,685	5,005	8,133	25,509	134,969
Fertility Rate* (CY98)	70.8	64.6	74.7	67.5	64.3	76.3	68.7	73.0	69.7	91.4	100.9	75.8
% First Trimester Prenatal Care (CY98)	76.7%	80.5%	81.3%	79.3%	82.4%	81.9%	81.5%	84.7%	73.3%	65.7%	68.9%	79.3%
% Low Birth Weight Births (CY98)	9.0%	7.4%	7.5%	7.8%	8.1%	7.4%	7.2%	7.3%	8.1%	7.2%	6.7%	7.4%
Neonatal Mortality Rate** (CY98)	5.3	5.1	4.2	4.2	5.3	3.7	3.6	4.5	3.6	3.8	2.9	4.0
Infant Mortality Rate** (CY98)	8.4	8.4	6.4	7.6	9.3	6.3	6.2	6.5	5.4	6.1	4.6	6.4
Maternal Mortality Rate*** (CY98)	8.2	0.0	6.8	0.0	0.0	3.7	0.0	11.6	0.0	6.7	0.0	4.4
Fetal Death Ratio** (CY98)	6.2	6.1	5.4	6.5	6.2	5.8	6.3	5.4	6.8	6.4	5.3	5.8
Rate of Childbearing Women with HIV^ (CY97)	0.0	0.0	0.6	1.8	3.3	2.4	0.5	0.5	0.0	0.3	0.2	1.1
Sudden Infant Death Syndrome (SIDS) Rate** (C\)	1.5	0.8	0.6	1.4	1.2	0.57	0.74	0.35	0.48	0.61	0.45	0.64
Neural Tube Defect Rate^^ (CY98)	10.7	5.4	7.0	7.9	9.0	8.6	6.3	7.9	7.2	9.4	11.9	8.2
# Infants Receiving THSteps Checkup (CY99)	7,253	3,968	28,782	7,476	5,633	27,578	11,133	14,403	5,025	8,264	25,559	145,074
Kessner Index of Adequate Prenatal Care (CY98)	68.9%	73.1%	73.3%	73.0%	77.1%	74.9%	76.2%	80.4%	64.3%	52.4%	61.2%	72.1%
% Breastfeeding WIC Enrollees (CY99)	28.0%	29.4%	41.5%	30.3%	30.5%	47.2%	40.4%	31.5%	29.0%	40.5%	40.8%	35.4%

*Rate per 1,000 women age 15-44

**Rate per 1,000 live births

***Rate per 100,000 live births

^Rate per 1,000 women tested of all ages

^^Rate per 10,000 live births

Sources:

Texas A&M University, Texas State Data Center, 1998 Population Estimates

TDH, R&PHA, Estimated Population in Need for Title V Excluding Medicaid Eligibles, 1998

TDH, Bureau of Vital Statistics, 1998 Texas Vital Statistics Report

TDH, Bureau of HIV and STD Prevention, 1997 Survey of Childbearing Women

TDH, Bureau of Vital Statistics, Natality Files

NHIC, HMPR980K 1997-99; HCFA-2082 1998; HCFA 416 1997

Bureau of Nutrition Services, Texas WIN, Client Certification History and Client History Tables

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

Pregnant Women, Women of Childbearing Age, and Infants

Needs Assessment Indicators by Region/County for Pregnant Women, Women of Childbearing Age, and Infants.

Table 4 above shows that there were more than 4.4 million women of childbearing age in Texas in 1998, close to 50% of whom resided in public health region (PHR) 3 and PHR 6. Harris (PHR 6) and Dallas (PHR 3) Counties contained the highest numbers of childbearing women, with 731,335 and 463,831, respectively. Statewide, about 27% of women of childbearing age were women-in-need of Title V services. The highest proportions of women-in-need were in Cullberson and Hudspeth (PHR 10), Concho (PHR 9), Real and Zavala (PHR 8), Castro and Crosby (PHR 1), Kenedy and Jim Hogg (PHR 11) counties, each varying from 50% to 60%, and the lowest proportions were in Collin, Rockwall, and Denton (all in PHR 3), Fort Bend (PHR 6), Williamson (PHR 7) Counties, each with 20% or less.

Four of the nine counties with high numbers of women of childbearing age varying from 100,000 to over 731,000 had fertility rates below the state average of 75.8 live births per 1,000 women of childbearing age. In counties with at least 50 live births, the highest fertility rate was in Travis (PHR 7) at 119, and the lowest rate was in Clay (PHR 2), with 43.2 live births per 1,000 women of childbearing age.

In 1998, there were 342,199 live births to Texas residents. Approximately 40% of all deliveries were funded by the state Medicaid program. The highest number of Medicaid-funded births was in PHR 6 (26,925 or 20% of the state total), and the lowest was in PHR 2 (3,894 or 3%).

In 1998, 7.4% of all live births in Texas were categorized as low birthweight (less than 2,500 grams). PHR 1 with 9% had the highest percentage of low birthweight, followed by PHR 5 and PHR 9, each with 8.1%. These two PHRs ranked among the lowest in terms of number of childbearing women and number of live births. Among all counties, Dickens (PHR 1) had the highest percentage of low birthweight, 21.4%, followed by Oldham (PHR 1) and Baylor (PHR 2), with 19.2% and 18.8%, respectively. In the remaining 215 counties with at least 50 live births, Mills (PHR 7) and Floyd (PHR 1) had the highest percentages of 16.1% and 13.9%, respectively, and San Saba (PHR 7) and Refugio (PHR 11) counties had the lowest low birthweight percentages, 4% and 5%, respectively. Twenty-one counties presented no low births, none of which exceeded 50 live births.

Texas neonatal and infant mortality rates were 4.0 and 6.4 per 1,000 live births, respectively. The highest neonatal mortality rate was in PHR 1 and PHR 5, with 5.3 per 1,000 live births, and the lowest was in PHR 11, with 2.9. Among counties with at least 50 live births, Carson (PHR 1) county had the highest neonatal mortality rate with 24.7 per 1,000 live births, followed by San Augustine (PHR 5), 20.8, and Aransas (PHR 11), 17.1. In contrast, 59 counties with at least 50 live births showed no neonatal deaths. PHR 5 had the highest infant mortality rate, 9.3 per 1,000 live births, and PHR 11 had the lowest rate of 4.6 per 1,000 live births. Among

counties with at least 50 live births, infant mortality rates for 1998 ranged from a high of 35.7 per 1,000 live births in Rains (PHR 4) to no infant deaths in 40 counties.

In 1998, 79.3% of pregnant women in Texas received prenatal care in the first trimester. PHR 8, with 84.7%, and PHR 5, with 82.4%, took the lead in providing prenatal care to the largest proportions of pregnant women in the first trimester, while PHR 10, with 65.7%, had the lowest proportion of women served. Statewide, proportions among counties with at least 50 live births ranged from highs of 92.6% in Kendall (PHR 8) and Llano (PHR 7) Counties to a low of 54.5% in Floyd County (PHR 1). Furthermore, 72% of all live births to Texas residents were to women who received adequate prenatal care. This represents an increase of 6.4% from 1994, when the percentage was 67.7%. PHR 8 and PHR 5 with 80.4% and 77%, respectively, accounted for the largest proportions in providing adequate prenatal care, while PHR 11, with 61%, had the lowest proportion. An associated health status indicator that may be influenced by the provision of prenatal care and its adequacy is the fetal death ratio. The Texas fetal death ratio was 5.8 per 1,000 live births in 1998. The ratio ranged from a high of 6.8 in PHR 9 to a low of 5.3 in PHR 11. Among counties with at least 50 live births, the highest rates were in Runnels (PHR 2) and Live Oak (PHR 11), with 29.6 and 25.9 per 1,000 live births, respectively. Fifty-one counties among these showed no fetal deaths.

While the statewide rate of maternal deaths was 4.4 per 100,000 live births, the great majority of the state's 254 counties registered no maternal deaths, with only seven counties reporting a total of 15 deaths. Of these deaths, six occurred in PHR 3, four in PHR 8, three in PHR 6, and one death in PHR 1 and PHR 10. Only three (Dallas, PHR 3; Bexar, PHR 8; and El Paso, PHR 10) of the seven Texas counties with at least 10,000 live births were included in these seven counties reporting maternal deaths.

In 1997, the rate of childbearing women with HIV was 1.1 per 1,000 women tested of all ages. Among the top Texas metropolitans, PHR 5 (Dallas) and PHR 6 (Houston) accounted for the highest rates of 3.3 and 2.4, respectively. Three PHRs showed no cases of childbearing women with HIV. Additionally, the overall rate per 1,000 women aged 20-44 with a reported case of chlamydia was 7.0 in 1998, representing an increase of nearly 23% from 1994. The highest rates recorded were in PHR1 and PHR 11 with 9.2 and 8.0, respectively.

Table 5

**Needs Assessment Indicators by Race/Ethnicity
For Pregnant Women, Women of Childbearing Age, and Infants.**

Public Health Region	African				TEXAS
	White	American	Hispanic	Other	
# of Women Age 15-44 (CY98)	2,519,258	565,030	1,292,163	121,712	4,498,163
# Women Eligible for Title V Age 15-44 (CY97)	384,689	208,346	593,059	31,996	1,218,090
# Live Births (CY98)	140,325	40,123	151,116	10,635	342,199
# Medicaid Deliveries (FY98)	32,112	17,504	83,503	1,850	134,969
Fertility Rate* (CY98)	58.9	70.8	107.2		75.8
% First Trimester Prenatal Care (CY98)	86.8%	75.7%	72.7%		79.3%
% Low Birth Weight Births (CY98)	6.8%	12.6%	6.7%		7.4%
Neonatal Mortality Rate** (CY98)	3.5	6.9	3.8	2.8	4.0
Infant Mortality Rate** (CY98)	5.6	11.6	5.9	3.9	6.4
Maternal Mortality Rate*** (CY98)	2.1	10.0	4.6		4.4
Fetal Death Ratio** (CY98)	2.2	1.1	2.2	0.2	5.8
Rate of Childbearing Women with HIV^ (CY97)	0.2	6.4	0.5	0.8	1.1
Sudden Infant Death Syndrome (SIDS) Rate** (CY98)	0.7	1.4	0.4	0.1	0.6
Neural Tube Defect Rate^^ (CY98)	7.0	6.2	10.0	7.5	8.2
# Infants Receiving THSteps Checkup (CY99)	35,292	20,854	85,321	3,607	145,074
Kessner Index of Adequate Prenatal Care (CY98)	81.4%	67.8%	63.5%		72.1%
% Breastfeeding WIC Enrollees (CY99)	31.6%	23.9%	42.7%		35.4%

*Rate per 1,000 women age 15-44

**Rate per 1,000 live births

***Rate per 100,000 live births

^Rate per 1,000 women tested of all ages

^^Rate per 10,000 live births

n/a = "Other" category included with White

Sources:

Texas A&M University, Texas State Data Center, 1998 Population Estimates

TDH, R&PHA, Estimated Population in Need for Title V Excluding Medicaid Eligibles, 1998

TDH, Bureau of Vital Statistics, 1998 Texas Vital Statistics Report

TDH, Bureau of HIV and STD Prevention, 1997 Survey of Childbearing Women

TDH, Bureau of Vital Statistics, Natality Files

NHIC, HMPR980K 1997-99; HCFA-2082 1998; HCFA 416 1997

Bureau of Nutrition Services, Texas WIN, Client Certification History and Client History Tables

Needs Assessment Indicators by Race/Ethnicity for Pregnant Women, Women of Childbearing Age, and Infants.

Table 5 above shows that a total of more than 4.4 million women of reproductive age resided Texas in 1998. White women comprised the largest group, with 2.2 million, followed by Hispanics with about 1.2 million women and African Americans with more than .5 million.

In 1998, Hispanics had the largest percentage (49%) of Title V women aged 15 to 44 years, followed by Whites (32%) and African Americans (17%). Moreover, 46% of Hispanic women of reproductive age and 37% of African Americans were women-in-need of Title V services, reflecting the high degree of poverty among these two groups. Only a relatively low percentage (15%) of White women were in need.

Of the 342,199 live births in 1998, 140,325 or 41% were White newborns, 40,123 or 12% were African-Americans, and 151,116 or 44% were Hispanics. More than 55% of Hispanic births were funded by Medicaid, followed by African American and White births with 44% and 23%, respectively. Fertility rates were highest for Hispanics, at 107.2 per 1,000 women aged 15-44 years, followed by African Americans and Whites at 70.8 and 58.9, respectively.

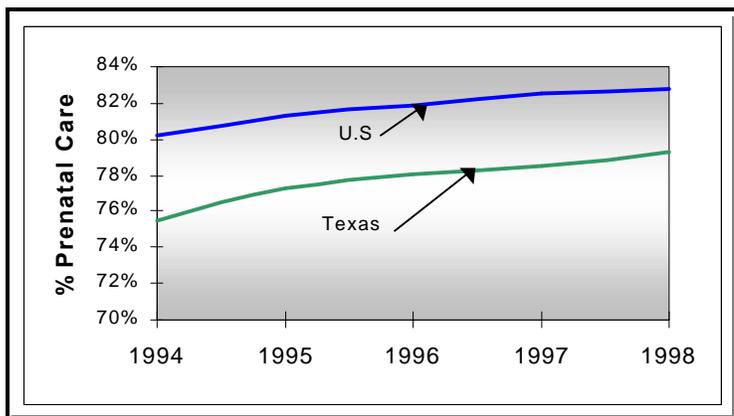
Data show that Hispanic women ranked last with 72.7% in receiving prenatal care services during the first trimester, behind Whites and African Americans with 86.8% and 75.7%, respectively. Despite the lowest percent of first trimester prenatal care, Hispanics with 6.7% had the lowest percentage of low birthweight, followed by White and African American low birth weight births with 6.8% and 12.6%, respectively. Concerning the receipt of adequate prenatal care, 81.4% of all live births to Texas residents were to White women, followed by African Americans and Hispanics with 68% and 64%, respectively. Furthermore, Hispanic and White women, each with 2.2 per 1,000 live births, accounted for higher fetal death ratios than African American women with 1.1.

African American neonatal and infant mortality rates were significantly higher than Whites and Hispanics rates. While the African American neonatal rate was 6.9 per 1,000 live births, Whites and Hispanics were 3.5 and 3.8, respectively. Moreover, while the African American infant mortality rate was 11.6 per 1,000 live births, White and Hispanic infants accounted for lesser mortality rates of 5.6 and 5.9, respectively.

African Americans had the highest maternal mortality rate at 10.0 per 100,000 live births, followed by Hispanics with 4.6, and Whites, with 2.1.

In 1997, the rate of African American women aged 15-44 years with HIV (6.4 per 1,000 women tested of all ages) was 32 times the rate of White (0.2) and at least 12 times the rate of Hispanic (0.5) childbearing women. Moreover, these rates were troublesome, since the number of African American childbearing women made up only 12.6% of the total women aged 15-44, while Whites and Hispanics were 56% and 29% respectively.

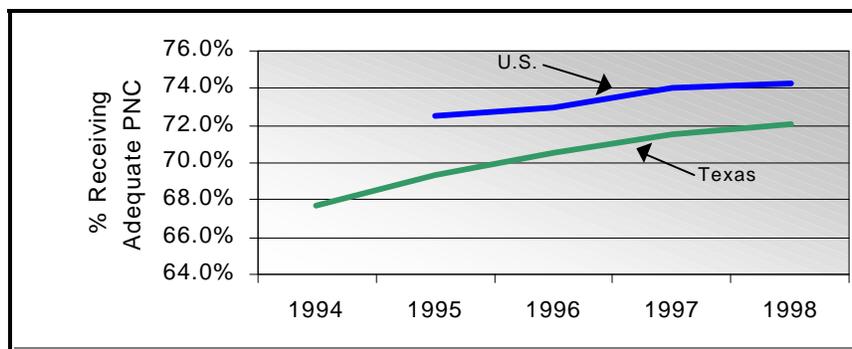
Data Analysis for Statewide Year 2000 Progress (HP 2010). In-depth data analysis (graphs included) for the following indicators is provided in Appendix D



Prenatal care. Modest progress was made in increasing the percentage of women who began prenatal care in the first trimester. The proportion of women receiving prenatal care in the first trimester in 1998 rose to 79.3%, up from 75.5% in 1994, representing an increase of 5% . Despite this increase, the percent of births to women with onset of prenatal care within the first trimester in Texas is consistently lower than the national average and still remains a challenge to achieve the Year 2010 objective of 90%.

In 1998, only 2% of Texas resident births were to women who reported receiving no prenatal care. Although White women were more likely than African American or Hispanic women to begin care during the first trimester, the percent of women receiving prenatal care in the first trimester increased for all race/ethnicity. Women aged 10-14 years were the least likely to receive prenatal care in the first trimester (52.6%) where women aged 30-34 years were the most likely (86.2%). Clearly, in order to achieve the HP 2010 objective, continued work is needed to educate women, particularly young women and African American and Hispanic women, about the need to begin prenatal care early in pregnancy.

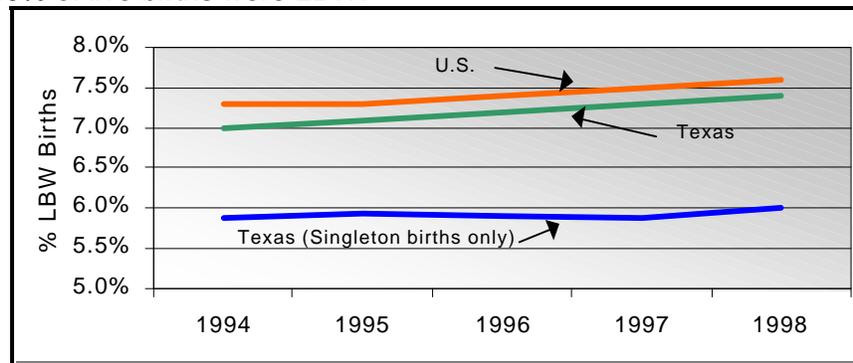
Adequacy of prenatal care. In 1998, 72.1% of all live births to Texas residents were to women who received adequate prenatal care, while only 7.5% received inadequate prenatal care, as measured by the Kessner Index. This is slightly lower than the national rate of 74.3% for the same year.



Data show that White women were more likely to receive adequate prenatal care (81.4%) than were either African American (67.9%) or Hispanic women (63.5%). It also appears that the youngest women aged 10-14 years as well as young women aged 15-24 years giving birth were less likely to receive adequate care than older women. Consequently, the Year 2010 objective to increase the proportion of women receiving adequate prenatal care to 90% remains a concern and a challenge for all race/ethnic groups. Continued efforts are needed to educate women at risk about the importance of the adequacy of prenatal care and to

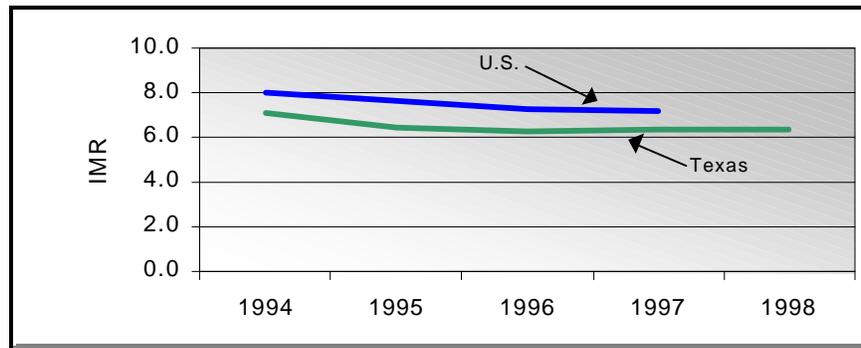
demonstrate that perinatal illness and disability and mortality rates are correlated with not only the monitoring of the month of initiation of prenatal care but also the adequacy of the care they receive throughout pregnancy.

Low birth weight births. There has been no improvement in the proportion of babies born with low birth weight births (LBW). In 1998, 7.4% of all live births to Texas residents were LBW (less than 2,500 grams or 5 pounds, 9 ounces). This represents an increase of 5.7% from 1994, when 7.0% of live births were LBW.



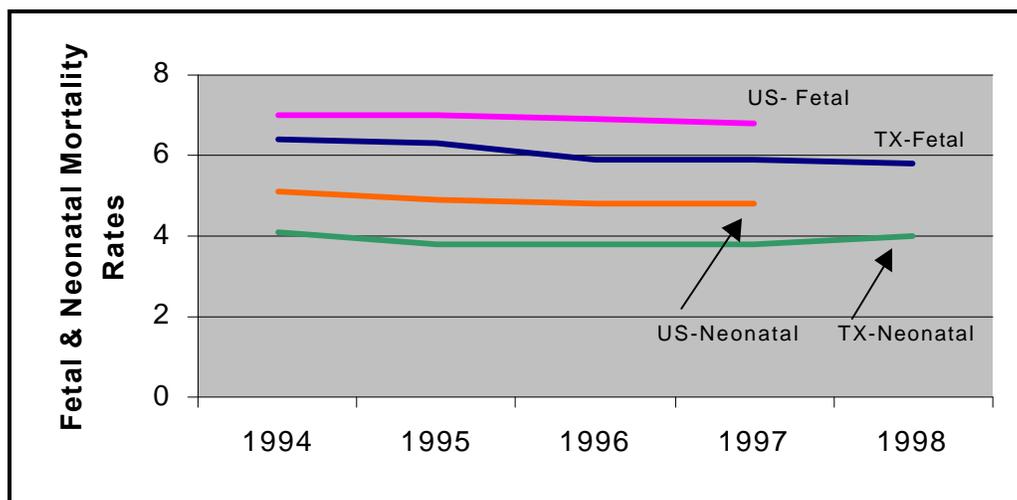
The increase in LBW births is due in great part to the increase of multiple births that has occurred in recent years. The percent of LBW single births has only increased about 1.7% from 1994 (5.9% LBW births) to 1998 (6.0% LBW births). About 59% of all multiple births in Texas in 1998 were LBW. Additionally, the birth rate of twins has increased 20% and rate of higher-order multiple births has increased 254% since 1990. The risk of giving birth to a LBW infant was much higher for African American mothers (12.6%) than for White mothers (6.8%) or Hispanic mothers (6.7%). The incidence of LBW births was higher for the youngest mothers aged 10-14 years and oldest mothers as well aged 40+, with 12.5% and 10.8% of births, respectively. Data show that decreasing the percent of LBW to meet HP 2010 objective of 5% is not only Texas' health issue but a nationwide one. Title V leadership recognizes the importance of LBW as the risk factor most closely associated with neonatal death; thus, improvements in infant birth weight can contribute substantially to reductions in the infant death rate. Clearly, in Texas, extensive educational efforts should be targeted toward African American childbearing women who are most likely to give births to a LBW infants compared to their White and Hispanic counterparts.

Infant Mortality Rate. There were 2,180 infant deaths to Texas residents in 1998 for an infant mortality rate 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 1996. However, the African American infant mortality rate (11.6) continues to be significantly higher than the infant mortality rates for White (5.6) or for Hispanic infants (5.9).



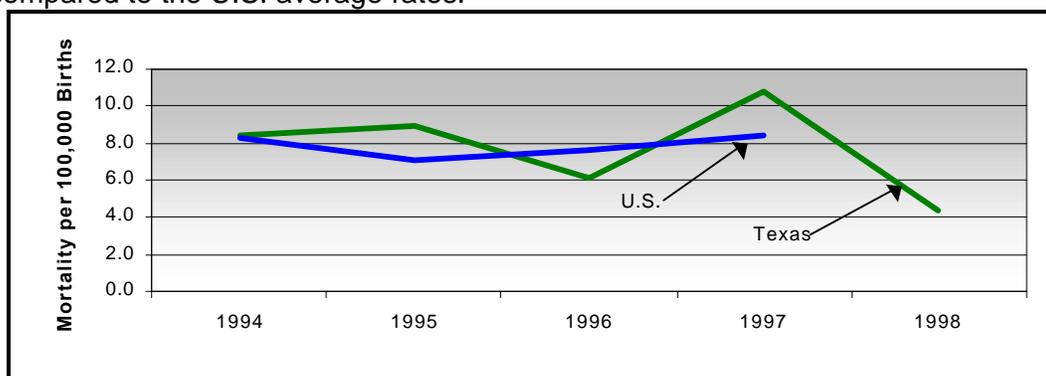
Congenital anomalies and sudden infant death syndrome accounted for 25% and 10% of all infant deaths, respectively. Disorders related to short gestation and LBW accounted for 12.1% and respiratory distress syndrome involved 4.4% of infant deaths. Sixty-two percent or 1,361 of infant deaths took place during the first 27 days-of-life. The rate in Texas for 1997 and 1998 is somewhat higher than in 1996, whereas the national rate decreased between 1996 and 1997. The infant mortality rate in Texas continues to be much lower than the U.S. average. Efforts should be continued toward reducing the infant mortality to meet the Year 2010 objective of 4.5 infant deaths per 1,000 live births, particularly among African American childbearing women.

Fetal and Neonatal Mortality Rates. There were 1,361 neonatal deaths in 1998. The neonatal death rate decreased in Texas from 1994 through 1997 and in 1998, there was a slight increase of 0.2%. This increased survival rate in Texas is possibly due to improved medical technology and staff training in intensive care units for newborns. Data appear to show the same pattern regarding the fetal mortality rates throughout the years. The fetal death rate decreased in Texas from 1994 through 1997 and in 1998, the rate experienced an increase of 0.1%. Nationally, both the neonatal and fetal death rates have decreased each year from 1994 through 1997 and are consistently higher than the Texas rates .



As the result of the high incidence of LBW births among African American childbearing women, the risk of neonatal deaths was much higher for African American infants (6.9 per 1,000) than those of White (3.5) or for Hispanic infants (3.8). However, fetal death ratio for African American infants was 1.1 per 1,000 live births in 1998 compared to 2.2 per 1,000 for each White and Hispanic infants. Despite the fact that Texas fetal and neonatal rates are better than the U.S. average rates, both health status parameters remain a challenge for the Texas Title V program to meet 2010 targets. Again, continued efforts are needed to implant gradually, particularly among African American childbearing women, the importance of early and adequate prenatal care in order to contribute substantially to reductions in LBW births and, in turn, in neonatal deaths and infant mortality rate.

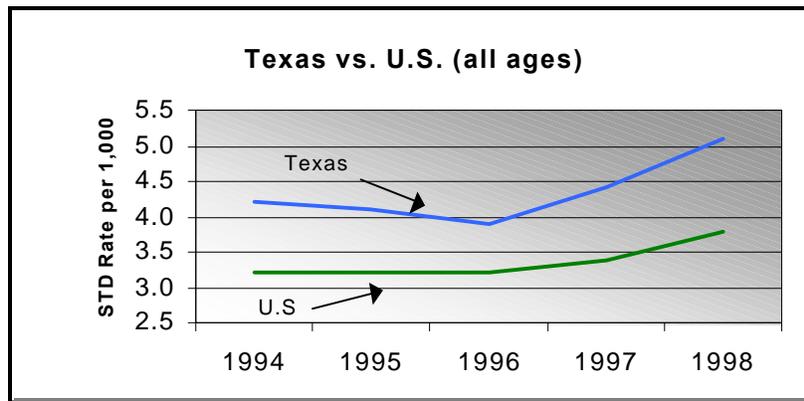
Maternal Mortality Rate. In 1998, 4.4 per 100,000 live births in Texas resulted in maternal deaths, totaling 15 deaths overall. This represents a decrease of 48% from 1994, when the rate was 8.4 per 100,000. The 1998 drop (15 deaths) could be the result of common fluctuation due to small numbers. In Texas, the annual rate since 1982 has been approximately 7.9, dropping to 7.7 with the inclusion of 1998's lowest rate ever. Achieving the 2010 target of 3.3 maternal rate per 100,000 live births this year for Texas would have meant no more than 11 maternal deaths. The graph below shows Texas mortality rates from 1994 to 1998 compared to the U.S. average rates.



The total number of maternal deaths has fluctuated from 27 in 1994 to 15 in 1998. Moreover, the gap between African Americans and Whites still remains, with the maternal mortality rate among African Americans close to five times that of Whites in 1998. Clearly, targeted preventive interventions are needed to increase awareness, particularly among African American women, of the leading causes of maternal deaths in Texas which can be prevented. Early diagnosis and appropriate medical care of pregnancy complications are the focus of these awareness efforts to reduce maternal deaths due primarily to hemorrhages, ectopic pregnancy, pregnancy-induced hypertension, and embolism.

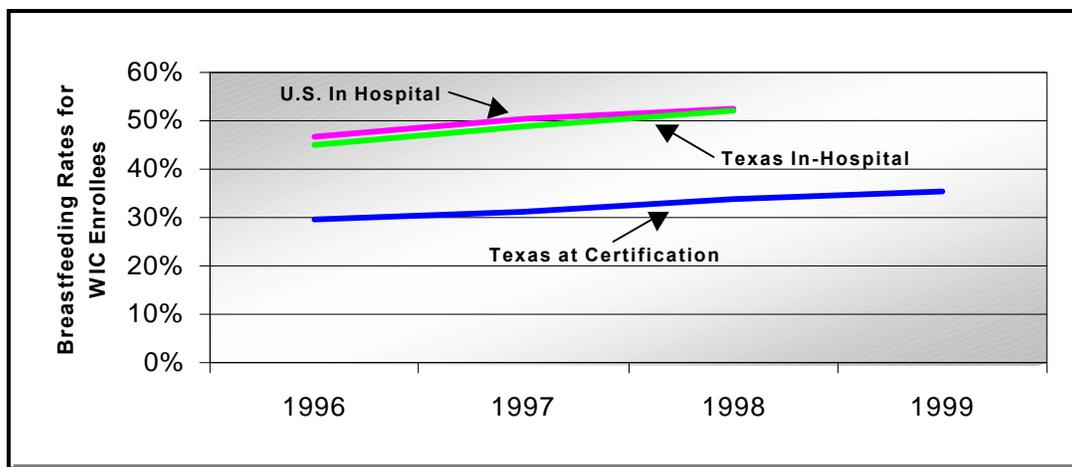
Sexually Transmitted Disease - Chlamydia. Despite a steady progress toward lowering the rates for chlamydia for Texas women aged 20-44 between 1994 and 1996, rates increased sharply in both 1997 and 1998. On the national level, the rates experienced an increase in 1997 and 1998 but were still lower than those in Texas for women all ages, including the 20-44

age group.



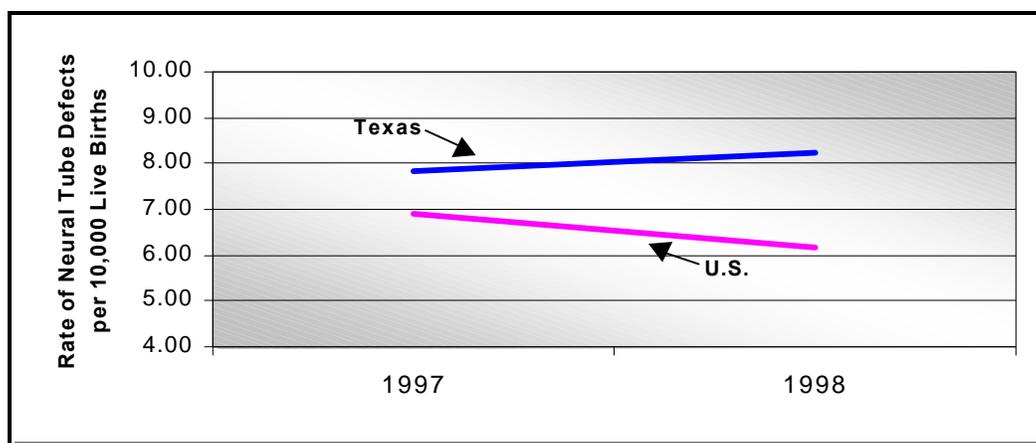
In 1998, the rate per 1,000 women aged 20-44 with a reported case of chlamydia was 7.0. This represents an increase of 22.8% from 1994, when the rate per 1,000 women was 5.7. Of the 26,126 reported cases of chlamydia, 5,928 were African American women (12.7 per 1,000), 9,238 were Hispanic women (8.8 per 1,000), and 3,444 White women (1.5 per 1,000). Moreover, these rates were troublesome, since the number of African American childbearing women made up only 12.6% of the total women ages 15-44, while Whites and Hispanics were 56% and 29%, respectively. Additionally, data show that the likelihood for women contracting chlamydia diminished with age. The rate of infection for women aged 20-24 years was the highest at 22.4 cases per 1,000, followed by 8.6 for women aged 25-29 years, 3.1 for women aged 30-34 years, 1.2 for women aged 35-39 years, and only 0.5 for women aged 40-44 years. Texas should strive to reduce significantly the burden of chlamydia in particular and STDs in general on its citizens. Through a collaborative and multifaceted approach, Title V is committed to eliminating age, racial, and ethnic disparities by making high-quality health care accessible for early detection, treatment, and behavior-change counseling for STDs.

Breast-feeding. Data indicate that both Texas and U.S. average percentages of breast-feeding WIC enrollees have increased since 1996. However, in Texas, the breast-feeding percentage of WIC enrollees in the hospital was slightly lower than the U.S. average.



In 1999, 35.35% of WIC enrollees who had given birth breast-fed their infants. This represents an increase of 5.7% from 1996, when 29.65% of WIC enrollees nursed. Hispanic (42.71%) enrollees were more likely to breast-feed than African American (23.86%) or White (31.56%) enrollees. In addition, the likelihood of breast-feeding increased with the age of the enrollee. The lowest breast-feeding percentage (14.5%) was found among 10-14 years old adolescents whose infants are at highest risk of poor health and development and the highest percentage was among women aged 35-59 years. While this breast-feeding increase over the years is encouraging, education of new mothers and their partners, education of health providers, and social support including support from employers are needed to increase rates among those at highest risk of not breast-feeding their newborns and to move Texas closer to the national targets of 75% at early postpartum period, 50% at 6 months, and 25% at one year.

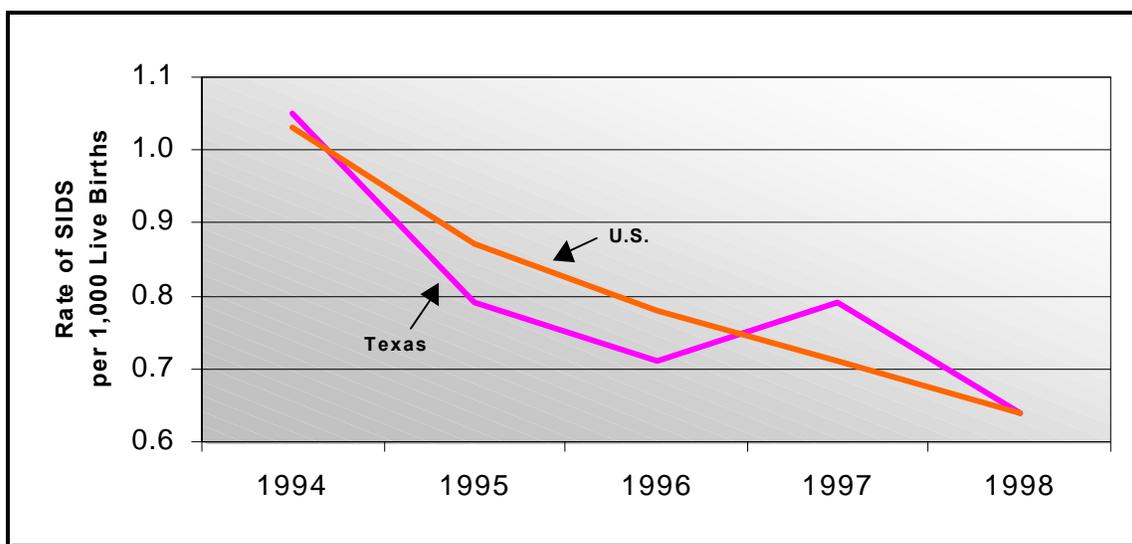
Neural Tube Defects. The graph below shows that the U.S. average number of reported cases of neural tube defects decreased in 1997 and 1998, ending with a rate of 6.17 per 10,000 births. In contrast, the number of neural tube defects for Texas newborns increased from 262 in 1997 to 282 in 1998, resulting an overall rate of 8.24 per 10,000 births.



Of the 282 reported cases of NTDs, 151 were to Hispanic mothers who gave birth to newborns with NTDs (9.99 per 10,000), followed by 25 African American (6.23 per 10,000) and 98 White mothers. In recent years, there has been a concerted effort from the Title V program to deploy resources along the 14 Texas-Mexico border counties to reduce the NTD cases to at least the national goal of 6 occurrences per 10,000 births. This 14-county area preventive intervention is designed 1) to identify and enroll high-risk women in folic acid intervention and provide folic acid supplementation, and 2) to conduct a case-control study of women identified through surveillance who reside in the 14-county study area at the time of the delivery or termination of their NTD-affected pregnancy.

Sudden Infant Death Syndrome (SIDS). Both Texas and the U.S. average rates of deaths due to Sudden Infant Death Syndrome (SIDS) for infants less than 1 year-of-age per 1,000 births experienced decreases throughout the years from 1994 to 1998, each ending with a rate of 0.64 per 1,000 births.

Despite the lowest recorded rate of 0.64 deaths due to SIDS in the past five years, rates for African American infant deaths from SIDS (1.42 per 1,000 births in 1998) remained significantly higher compared to those for Hispanic (0.38 per 1,000 births) and White (0.73 per 1,000 births) infants. In 1998, there were 218 death cases due to SIDS, making SIDS one of the leading causes of postneonatal among all racial and ethnic groups. Therefore, a reduction in the rate of death from SIDS, particularly among African American infants, would contribute greatly to reducing the overall infant mortality and particularly to closing the racial gap in postneonatal death. The national target of 0.30 deaths per 1,000 live births should be achieved by 2010 through continued education.



Infants receiving a Texas Health Steps (THSteps) checkup. Infants enrolled in the THSteps program are expected to have 6 checkups in their first year. In 1999, data shows that 79% of the expected number of infants received checkups. With continued efforts such as marketing and outreach campaigns, Texas infant participation in Medicaid is near reaching the Health Care Financing Administration's goal of 80% participation. Nationally, the participation rate for infants in 1997 was 74%.

State-level needs assessment projects that support more intensive folic acid awareness programs and confirm the need for family violence reduction

Neural Tube Defects. The TDH Texas Birth Defects Research Center, in collaboration with the Bureau of Clinical and Nutrition Services, designed a telephone survey to measure the level of Texas women's daily use of supplements and awareness of folic acid.

Among the 334,197 Texas live births recorded in 1996, an estimated 270 pregnancies of mothers aged 15-44 resulted in a diagnosis of a neural tube defect, either spina bifida or anencephaly. Studies show that these serious forms of birth defects are preventable in most women who adopt pre-conception planning behaviors, such as consuming folic acid daily. Women who consume the B vitamin folic acid daily prior to conception or early in pregnancy can reduce the occurrence of spina bifida and anencephaly by at least 70%.

All TDH public health regions (PHRs) were part of the study, so that geographic differences among women could be measured. The regional sampling plan called for the completion of 100 interviews in each public health region and included over sampling African-American and Hispanic women in order to measure race/ethnicity differences among women in Texas. The overall response rate for the study was 84.1%. The weighted data analysis provides the 1997 baseline prevalence measures of Texas women's daily consumption of supplements and awareness of folic acid:

1. Daily Supplement Use. The interviewer asked respondents, "Do you currently take any vitamin or mineral supplements on a daily basis?" Forty-two percent of all Texas women reported that they currently take some type of daily vitamin or mineral supplement. For white women, 233 out of 493 (47.3%) took daily supplements. Out of 292 African-American women who participated in the study, only 103 (35.3%) reported taking daily supplements, while 32% (140 out of 441) of Hispanic women reported daily consumption of supplements. The group response of women who reported "other race/ethnicity categories" was excluded due to the heterogeneity of the category and small sample size (n=49).

The data show a positive relationship between reported household income and daily use of supplements. The higher the income, the higher the reported use of daily supplements. Forty-five percent of women who reported household income of \$25,000 and higher reported daily consumption of supplements. Only 32% of women with household income of less than \$25,000 reported taking daily vitamin or mineral supplements.

The reported daily supplement use by women residing in east Texas (PHRs 4&5) and the Lower Rio Grande Valley (PHR 11) is significantly lower than that reported by women in southeast Texas, including Houston (PHR 6), and north Texas, including Dallas (PHR 3).

The regional differences in daily consumption of supplements partially reflects aggregate patterns of residence by race/ethnicity. Forty-seven percent of the sample residing in east Texas (PHRs 4&5) are African-American women, while 78% of the sample residing in south Texas (PHR 11) are Hispanic.

2. Folic Acid Awareness. The interviewer asked respondents "Have you ever heard or read anything about folic acid?" Sixty-six percent of all women reported an awareness of folic acid. Texas women reported having an awareness of folic acid 1½ times more often than they reported taking vitamins or mineral supplements daily.

There is a significant difference in folic acid awareness by age of respondent. In the 24-44 age group, 639 out of 901 (71%) women reported having heard or read about folic acid. Only 52% (193 out of 372) of younger women reported an awareness of folic acid.

Seventy-three percent of white women reported having ever heard or read about folic acid. Only 56% of African-American women and 53% of Hispanic women reported

having an awareness of folic acid.

The findings show a positive relationship between reported household income and folic acid awareness. The women reporting the highest household income also most frequently reported that they had heard of read about folic acid.

No significant differences were observed between regions, although lower awareness (58%) was observed among the 191 women living within the 14 Texas counties that border Mexico. Although the findings show that there is little difference in folic acid awareness among women across TDH PHRs, women living in the Lower Rio Grande Valley reported lower daily use of supplements. Residents from this same region experienced a cluster of neural tube defects (NTDs) in 1991, as well as high NTD rates in those Texas counties that border Mexico. Women who reside in this region would be an ideal target for more intensive folic acid awareness programs and birth defects prevention efforts to reduce the occurrence of NTDs in that area.

Family Violence. In 1993, the federal Department of Health and Human Services initiated a 5-year Title X Service Enhancement Project related to family violence in Region VI (Texas, Arkansas, Oklahoma, Louisiana, and New Mexico). Among the five states, 14 family planning clinics were designated as pilot sites. Of these clinics, four TDH family planning contractors located in Houston, Forth Worth, Corpus Christi, and Galveston were selected to participate in the project. The specific goals of the Texas project were: 1) to determine the prevalence of sexual abuse and family violence in a sample of family planning clients at selected sites; 2) to expand and enhance services to include brief on-site counseling, followed by referral for in-depth services; and 3) to provide community prevention education.

During the first 2 years of the project, women receiving family planning services were surveyed and data were collected on abuse through the completion of a nine-page questionnaire. Over 2,000 women in all five states participated in this project. Of the women surveyed, 694 (31%) were from Texas. Of these, 189 women (27.3%) said they had experienced some form of sexual assault. Of the 675 Texas women who answered the question, "Have you ever been hit or injured by someone you were in a relationship with?", 255 (38%) said yes.

Since abuse to women could be reduced by as much as 75% if identification and intervention were offered in primary care settings, the Bureau of Women's Health staff conducted the following activities for family planning providers to prevent abuse and to identify victims:

- a. Policies and Protocols: The creation and distribution of a model protocol for victims of family/interpersonal violence are an effective means of promoting service expansion. The model policy manual directly addresses the issue of mandatory reporting and recommends treatment and referral options that are in compliance with Texas laws. The model protocol was sent to all family planning providers in January, 1997.
- b. Family Violence Service Expansion and Prevention Training: Approximately 50 presentations have been offered to family planning providers since the summer of 1995. The contents have changed over time and are always modified to include new information.

c. Capacity Building: Capacity building activities of the project have included both the development of a training design based on the provider training materials and a "Train the Trainer" workshop, co-sponsored by the Center for Health Training and presented in March, 1998.

d. Publications: In December, 1997, an article appeared in Disease Prevention News, a Texas Department of Health publication for physicians, entitled "Family Violence: What is a Health Care Provider to Do?" The article outlined screening and referral recommendations and referred to our experience with this project.

The next logical step is to continue expanding these activities to Title V and other interested health care providers through the implementation of the proposed state performance measure activities.

Table 6

**Needs Assessment Indicators By County/Region
For Preventive and Primary Care for Children and Adolescents**

Public Health Region	PHR 1	PHR 2	PHR 3	PHR 4	PHR 5	PHR 6	PHR 7	PHR 8	PHR 9	PHR 10	PHR 11	TEXAS
# of Children Age 0-21 (CY98)	271,792	180,086	1,721,630	311,344	233,979	1,610,573	764,786	723,586	193,240	283,318	683,447	6,977,781
Children Eligible for Title V Age 0-21 (CY97)	73,546	49,040	323,361	78,204	56,491	330,206	164,229	192,324	53,707	85,585	198,960	1,605,653
Teen Pregnancy Rate* Age 13-17 (CY98)	39.8	35.1	33.3	34.5	32.8	33.9	33.3	38.7	42.7	36.9	45.1	36.2
THSteps Eligibles Age 0-20 (FY98)	81,434	47,025	308,585	82,583	71,874	351,742	141,634	226,564	54,327	109,642	322,595	1,798,005
THSteps Eligibles Served Age 0-20 (CY98)	26,546	16,342	102,097	30,981	26,302	137,968	37,546	70,121	18,752	45,627	157,389	669,671
THSteps Checkups Provided Age 0-14 (CY99)	20,149	11,771	61,245	21,780	18,690	68,694	25,325	48,748	13,529	33,663	122,581	446,175
THSteps Dental Services Provided Age 1-14 (CY99)	16,692	11,626	69,041	19,026	16,398	115,588	31,696	63,506	11,436	37,014	121,349	513,372
Death Rate** by All Causes Age 0-4 (CY98)	203.6	202.1	153.7	211.5	232.6	153.0	16.9	156.7	123.3	136.5	116.3	156.6
Death Rate** by All Causes Age 5-14 (CY98)	21.1	20.4	16.7	34.9	33.5	18.4	23.9	19.5	26.0	21.2	16.7	20.2
Death Rate** by All Causes Age 15-24 (CY98)	73.1	65.0	91.5	117.9	97.6	90.3	73.9	79.0	68.8	69.9	78.5	85.0
Death Rate*** due to Motor Vehicle Accidents (CY98)	16.9	14.4	10.0	27.6	25.6	11.0	16.2	12.2	14.5	8.8	12.3	13.1
# Children Served by ECI^ (CY99)	1,522	885	6,606	1,202	946	5,560	2,718	3,615	789	1,102	2,517	27,462
Chlamydia Rate^^ to Children Age 15-19 (CY98)	36.2	29.0	29.5	24.5	25.9	29.4	27.6	34.9	25.8	17.8	21.6	28.4
Motor Vehicle Mortality Rate** Age 1-12 (CY98)	7.8	4.4	3.6	9.2	10.8	4.5	6.9	5.0	4.9	4.2	6.4	5.3
Motor Vehicle Mortality Rate** Age 13-19 (CY98)	28.8	27.0	20.4	47.6	48.2	19.0	27.0	22.4	27.5	17.6	24.0	24.4
Child Death Rate** Age 1-14 (CY98)	25.4	25.2	20.2	44.0	39.7	22.3	30.1	22.7	23.2	22.2	20.3	24.1
% Elevated Blood Lead Levels^^^ Age 1-5 (CY99)	0.30%	0.69%	0.30%	0.61%	0.44%	0.31%	0.45%	0.33%	0.28%	0.24%	0.45%	0.43%
Confirmed Child Abuse Rate† Age 0-15 (CY98)	1.2%	1.2%	0.7%	1.0%	1.2%	0.7%	1.0%	0.9%	0.7%	0.8%	0.7%	0.8%
%WIC Enrolled Children with Anemia Age 1-4 (CY99)	18.32%	19.66%	21.12%	32.31%	31.83%	26.31%	35.05%	22.74%	20.80%	6.72%	36.33%	26.06%
Suicide Rate** Age 13-19 (CY98)	7.8	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.0	0.1	0.1
Homicide Rate** Age 13-19 (CY98)	10.0	0.0	12.5	8.6	6.3	11.8	7.8	7.5	0.0	1.3	7.6	9.1
Dropout Rate Grade 7-12 (CY98)	1.2%	1.4%	1.2%	1.4%	1.5%	1.6%	1.3%	1.7%	2.0%	1.5%	1.9%	1.6%

*Rate per 1,000 women age 13-17
 **Rate per 100,000 in age appropriate population
 ***Rate per 100,000 children age 0-21
 ^Denotes children served by ECI in FY 1999
 ^^Rate per 1,000 women age 10-24 tested
 ^^Among Medicaid Eligible Resident Children in age appropriate population
 †Rate per 1000 Children in the Population

Sources:

- Texas A&M University, Texas State Data Center, 1998 Population Estimates
- TDH, R&PHA, Estimated Population in Need for Title V Excluding Medicaid Eligibles, 1998
- TDH, Bureau of Vital Statistics, 1998 Texas Vital Statistics Report
- TDH, Bureau of HIV and STD Prevention, 1997 Survey of Childbearing Women
- TDPRS, Forecasting and Program Statistics, CAPS; Child Welfare League of America; National Data Analysis System
- TDH Bureau of Nutrition Services, TexasWIN, Client Master and Client Nutritional Risk Tables
- NHIC, HMPR890K 1997-1999; HCFA-2082 1998; HCFA-416 1997
- TDH, Bureau of Vital Statistics, CDC, National Center for Injury Prevention and Control, Injury Mortality Data
- Texas Education Agency; National Center for Education Statistics, 1997

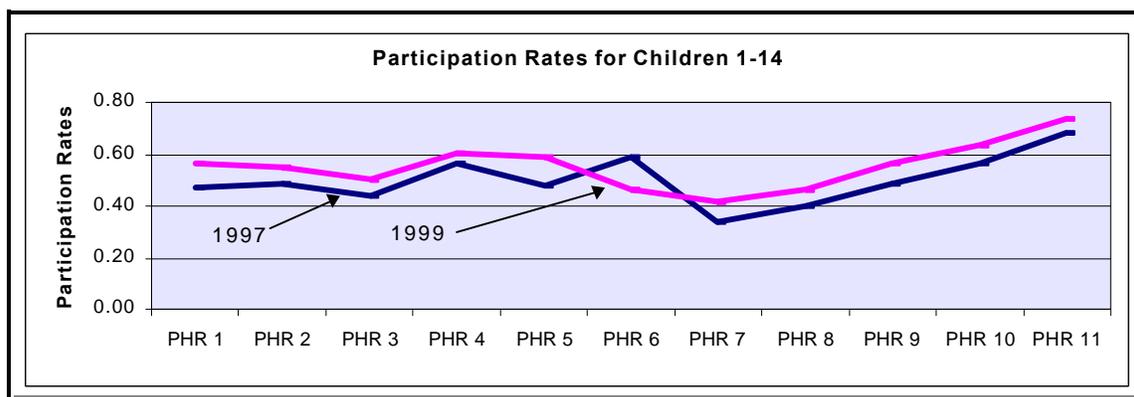
Children and Adolescents

Needs Assessment Indicators By County/Region for Preventive and Primary Care for Children and Adolescents.

In 1998, more than 6.9 million children and adolescents aged 0 to 21 years resided in Texas (Table 6 above). About 1,133,030 or 16% of them lived in Harris County (PHR 6). Thirty-four percent resided in Dallas (PHR 3), Bexar (PHR 8), Tarrant (PHR 3), El Paso (PHR 10), Travis (PHR 7), and Hidalgo (PHR 11) Counties. Among children aged 0 to 21 years, more than 1.6 million or 23% were children-in-need of Title V services. Of these, 15% were in Harris County (PHR 6), while the other six counties mentioned above contained 35% of the Title V eligible children and adolescents.

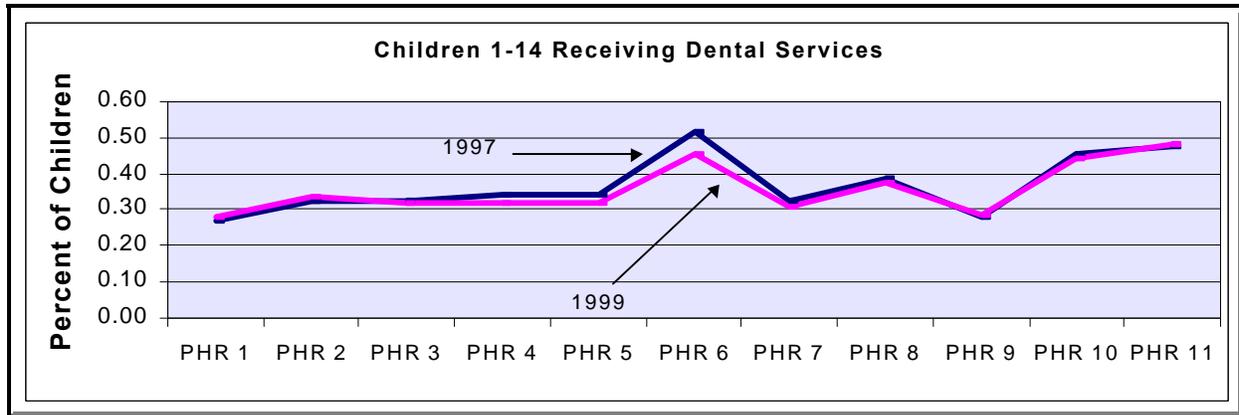
In 1998, Texas teen pregnancy rate was 36.2 per 1,000 women aged 13-17 years. PHR 11 had the highest teen pregnancy rate at 45.1 and PHR 5 had the lowest teen pregnancy rate at 32.8. Teen pregnancy rates for the seven most populous counties in Texas were 36.5 in Harris County, PHR 6; 41.7 in Dallas County, PHR 3; 40.4 in Bexar County, PHR 8; 34.9 in Tarrant County, PHR 3; 37.5 in El Paso, PHR 10; 40.7 in Travis County, PHR 7; and 42.3 in Hidalgo County, PHR 11.

Texas had a THSteps eligible population of over 1.7 million children and adolescents of whom 669,671 or 37%, were served in 1998. While Harris County (PHR 6) served about 41% of the total eligible children, the other six-most populous county group (Dallas, Bexar, Tarrant, El Paso, Travis, and Hidalgo Counties) served 36% of eligible children. In 1999, the number of children expected to receive a checkup was 803,538. Of these, 446,175 or 56% received medical check-ups. The graph below shows the regional participation rates for children 1-14. Every PHR's participation rate increased from 1997 to 1999 by a 5% to 9%, except PHR 6. The 11 point decline in PHR 6 kept the statewide increase to only 7.7% change. PHR 6 introduced HMO providers between 1997 and 1999, and the HMO data are poorly captured.



For the THSteps dental program, the number of children receiving services declined slightly from 557,364 to 513,312 (8%). Additionally, the percentage of eligible children receiving

services from 1998-1999 dropped from 40% to 39%. The largest decline was in PHR 6, which had the highest percentage in 1998 (52%) but dropped to second behind PHR 11 in 1999. The graph below shows the regional participation for children 1-14 receiving dental services.



In 1998, there were 5,514 Medicaid-eligible children aged 1-5 years with blood lead levels at or greater than 10mg/dL. Of these, 1,025 or 0.71% children screened presented high blood lead levels in PHR 11, followed by PHR 6 and PHR 3 with 880 or 0.51% and 790 or 0.52% positive cases of high blood lead levels, respectively.

In 1999, 27,462 children under three years received services from the Early Childhood Intervention (ECI) Program. The proportions of the total children served ranged from a low of 2.9% of children under three years in PHR 9 to a high of 24% in PHR 3.

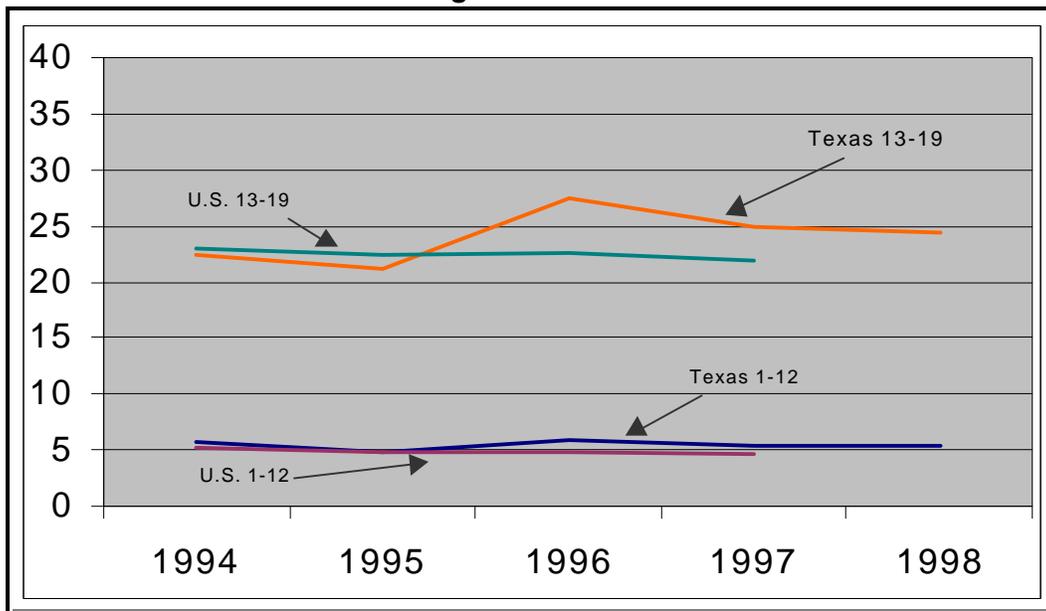
Deaths of children and adolescents due to all causes were broken down into three age groups: birth to age 4, age 5 to 14, and age 15 to 24. The birth to age 4 group displayed higher death rates than the other two age groups, with rates reaching a high of 233 per 100,000 children age 0-4 in PHR 5 and 212 in PHR 4. PHR 7 had the lowest death rate, at 17 per 100,000 children age 0-4. The highest county death rates were in Jeff Davis (PHR 10), with 2,410, Stonewall (PHR 2), with 1,389, and Jim Hogg (PHR 11), with 1,093. The statewide death rate for this age group was about 157 per 100,000 children age 0-4.

The children aged 5 to 14 group had the lowest death rates of the three age groups. The statewide rate for this group was 20 deaths per 100,000 children aged 5-14 years. The highest rate was about 35 deaths in PHR 4, and the lowest rates, at about 17, were in PHR 3 and PHR 11. The counties with the highest rates were McMullen (PHR 11), with 885, Stonewall (PHR 2), with 457, Coke (PHR 9), with 436, and Dickens (PHR 1), with 337 deaths per 100,000.

The 15 to 24 age group had much higher death rates than those of the 5 to 14 age group. The statewide rate for this group was 85 deaths per 100,000 children aged 15-24 years. The highest rate was 118 deaths per 100,000 in PHR 4, and the lowest rate, at 65 deaths, was in PHR 2. The following counties accounted for the highest death rates among adolescents aged 15-24 years: Collingsworth and Motley (PHR 1), with 671 and 546, respectively, Shackelford (PHR 2), with 545, and Irion (PHR 9), with 472.

In 1998, the Texas rate for motor vehicle injury deaths was about 13 per 100,000 children aged 0-21 years. The highest rate was 28 in PHR 4 and the lowest rate, at 9, was in PHR 10. At the county level, all highest five rates were in PHR 1 (Collinsworth with 289, Motley with 285, Dickens with 160, and Hansford with 159) with the exception of Franklin (PHR 4) with 117 motor vehicle injury deaths per 100,000 children aged 0-21 years. Similar to motor vehicle deaths, homicide and suicide are found to be among leading causes of deaths for adolescents. In 1998, the homicide rate per 100,000 of deaths to adolescents aged 13-19

**Motor Vehicle Deaths
of Children Aged 1-12 and 13-19 Years**



years was 9.1. Among PHRs with homicide cases, rates ranged from a low of 1.3 deaths per 100,000 in PHR 10 to a high of 12.5 per 100,000 in PHR 3. PHR 2 and PHR 10 showed no deaths due to homicide. Moreover, data indicate that suicide rates remained higher than the national averages between 1994 and 1998. The Texas suicide rate in 1998 was 7.7 per 100,000 of deaths to adolescents aged 13-19 years. While PHR 8 and PHR 10 accounted for the lowest suicide rates of 3.5 and 3.8 per 100,000, respectively, PHR 4 had the highest rate of 11.4 per 100,000.

The statewide chlamydia rate per 1,000 tested women aged 15-19 years was 28.4 in 1998. The highest rates were found in PHR 1(36.2) and PHR 8 (34.9) and the lowest rates were in PHR 11 (21.6) and PHR 10 (17.8). More than one-third of the Texas counties had fewer than 15 cases of children or adolescents who contracted chlamydia.

In 1998, Texas recorded a dropout rate of 1.6 for adolescents in grades 7-12. The distribution of dropout rates remained constant among PHRs. The highest dropout rates of 2.0 and 1.9 were in PHR 9 and PHR 11, respectively.

The distribution of the 41,439 cases of child abuse and or neglect was somewhat balanced among PHRs. The highest percentage (1.2%) of child abuse was in PHR 1, PHR 2, and PHR 5. One of the populous PHRs which recorded only 0.7% was PHR 6 (Houston, Harris County).

The overall percentage of WIC enrolled children 1-4 years with anemia decreased from 32.49% in 1995 to 26.06% in 1999. Similar trends occurred among all PHRs. However, the highest percentages of children with anemia were recorded in PHR 11 and PHR 7 with 36% and 35%, respectively, and the lowest percentage (7%) was in PHR 10.

Table 7

**Needs Assessment Indicators By Race/Ethnicity
For Preventive and Primary Care for Children and Adolescents**

Public Health Region	African				TEXAS
	White	American	Hispanic	Other	
# of Children Age 0-21 (CY98)	3,407,760	885,134	2,504,610	180,277	6,977,781
Children Eligible for Title V Age 0-21 (CY97)	441,389	274,887	856,741	32,636	1,605,653
Teen Pregnancy Rate* Age 13-17 (CY98)	19.3	48.2	58.7	17.3	36.2
Death Rate** by All Causes Age 0-4 (CY98)	133.7	283.9	148.5	92.7	156.6
Death Rate** by All Causes Age 5-14 (CY98)	18.9	30.1	18.5	17.3	20.2
Death Rate** by All Causes Age 15-24 (CY98)	72.9	105.4	99.9	46.9	85.0
Death Rate*** due to Motor Vehicle Accidents (CY98)	13.9	11.9	13.2	3.9	13.1
# Children Enrolled in ECI^ (CY99)	5,904	2,160	5,934	363	14,361
Chlamydia Rate^^ to Children Age 15-19 (CY98)	8.4	57.4	26.3		28.4
Motor Vehicle Mortality Rate** Age 1-12 (CY98)	4.1	9.0	5.7		5.3
Motor Vehicle Mortality Rate** Age 13-19 (CY98)	27.1	15.2	24.9		24.4
Child Death Rate** Age 1-14 (CY98)	21.9	39.2	22.3		24.1
% Elevated Blood Lead Levels^^^ Age 1-5 (CY98)	0.50%	0.87%	0.70%	0.93%	0.66%
Confirmed Child Abuse Rate† Age 0-15 (CY98)	0.7%	0.6%	0.7%		0.8%
%WIC Enrolled Children with Anemia Age 1-4 (CY99)	23.26%	29.17%	26.27%	21.20%	26.06%
Suicide Rate** Age 13-19 (CY98)	8.2	4.7	8.0	0.0	7.7
Homicide Rate** Age 13-19 (CY98)	3.4	24.2	12.8		9.1
Dropout Rate Grade 7-12 (CY98)	0.9%	2.1%	2.3%	1.1%	1.6%

*Rate per 1,000 women age 13-17

**Rate per 100,000 in age appropriate population

***Rate per 100,000 children age 0-21

^Denotes children served by ECI in FY 1999

^^Rate per 1,000 women age 10-24 tested

^^^Among Medicaid Eligible Resident Children in age appropriate population

†Rate per 1000 Children in the Population

Sources:

Texas A&M University, Texas State Data Center, 1998 Population Estimates

TDH, R&PHA, Estimated Population in Need for Title V Excluding Medicaid Eligibles, 1998

TDH, Bureau of Vital Statistics, 1998 Texas Vital Statistics Report

TDH, Bureau of HIV and STD Prevention, 1997 Survey of Childbearing Women

TDPRS, Forecasting and Program Statistics, CAPS; Child Welfare League of America; National Data Analysis System

TDH Bureau of Nutrition Services, TexasWIN, Client Master and Client Nutritional Risk Tables

NHIC, HMPR890K 1997-1999; HCFA-2082 1998; HCFA-416 1997

TDH, Bureau of Vital Statistics, CDC, National Center for Injury Prevention and Control, Injury Mortality Data

Texas Education Agency; National Center for Education Statistics, 1997

Needs Assessment Indicators By Race/Ethnicity for Preventive and Primary Care for Children and Adolescents.

Table 7 above shows that children-in-need of Title V services (e.g., preventive and primary care, sub-specialty medical care, case management) consisted of 23% of the total number of children ages 0-21 in Texas in 1998. Hispanics had the largest proportion (53%) of children-in-need followed by Whites (27%) and African Americans (17%). Furthermore, while about 13% of White children ages 0-21 years were children-in-need in 1998, Hispanic and African American children-in-need accounted for 34% and 31% of their respective total populations of children ages 0-21 years.

In 1998, teen pregnancy rates were the highest for Hispanics at 58.7 per 1,000 women aged 13-17 years, followed by 48.2 for African Americans. The pregnancy rate for White teens was 19.3 per 1,000 teens age 13-17.

African Americans consistently had the highest rate of deaths per 100,000 children by all causes at ages 0-4, 5-14, and 15-24 in 1998. The death rates for African American children by all causes were twice of that White or Hispanic children for all age groups. On the other hand, Whites (13.9 per 100,000 children aged 0-21 years) had the highest rate of motor vehicle injury deaths, followed by Hispanics (13.2) and African Americans (11.9).

In 1998, the statewide chlamydia rate per 1,000 tested women aged 15-19 years was 28.4. African Americans had the highest rate at 57.4 per 1,000, followed by Hispanics and Whites, with 26.3 and 8.4, respectively.

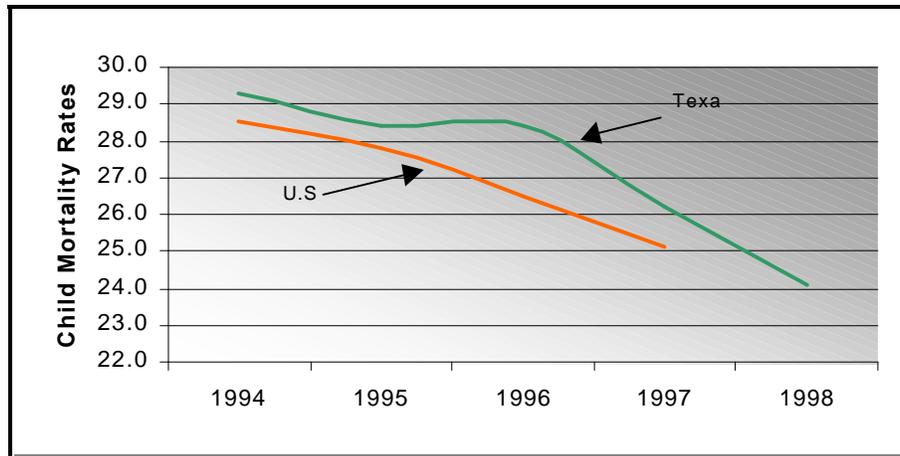
Motor vehicle crashes, homicide and suicide were among the leading causes of death for adolescents. The Texas rate for motor vehicle injury deaths in 1998 was highest for Whites, with 13.9 per 100,000 children aged 0-21 years, followed by Hispanics and African Americans, with 13.2 and 11.9, respectively. Similar distributions were observed for suicide rates. The rate among White adolescents was 8.2 per 100,000 adolescents aged 13-19 years in 1998 and Hispanics and African Americans accounted for 8.0 and 4.7, respectively. However, in 1998, homicide was the leading cause of deaths for African Americans aged 13-19 years. African American (24.2 per 100,000) and Hispanic (12.8 per 100,000) adolescents had a higher rate of homicide than did white (3.4 per 100,000).

The dropout rate for adolescents in grades 7 through 12 was 1.6% in 1998. Of the 27,550 recorded dropouts, Hispanics youth accounted for 14,127 or 51%, Whites and African Americans with 7,734 or 28% and 5,152 or 19%, respectively.

In 1998, There were 5,514 Medicaid eligible children aged 1-5 years with high blood lead levels. Of the Hispanic children screened, 3,184 cases or 0.70% were positive for high blood lead levels. African American and White children screened accounted for 1,182 or 0.87% and 8,270 or 0.50% of positive cases of high blood lead levels.

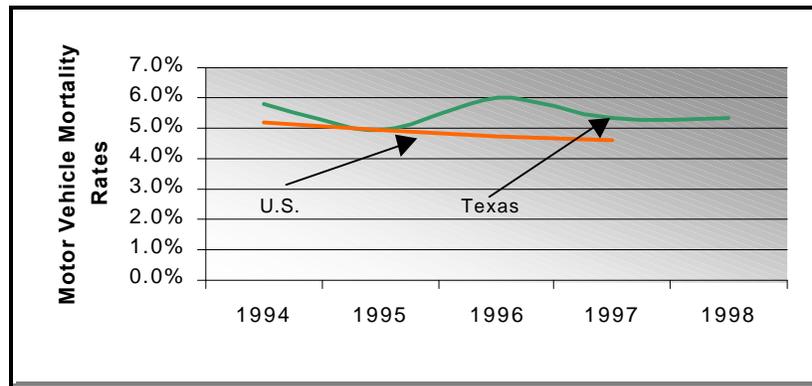
Data Analysis for Statewide Year 2000 Progress. In-depth data analysis for the following indicators is provided in Appendix D.

Child Death Rate. The number of deaths to children in Texas has decreased from 1994 to 1998, resulting to a mortality rate of 24.1 per 100,000 deaths. However, the child death rates in Texas are consistently higher than the U.S. averages.



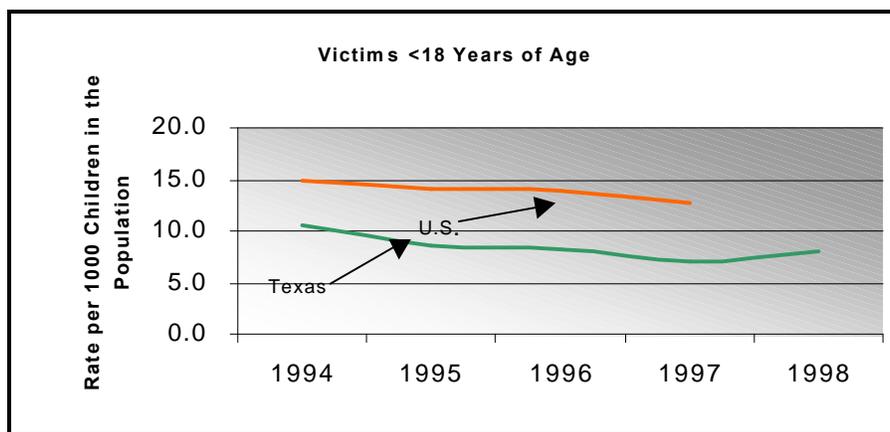
There were 1,073 child deaths to Texas residents aged 1-14 years in 1998, representing a mortality rate of 24.1 per 100,000 deaths. The disparities between White and African American groups in child deaths are wide. In 1998, the rate for African American child deaths was 39.2, where the Whites child death rate was 21.9 per 100,000 children aged 1-14 years. Additionally, an age disparity was present. The Texas death rate for children aged 1-14 years was dramatically higher in the 1-4 years old age group (33.1) than the 5-9 or 10-14 years old age groups, which were 16.7 and 24, respectively. The leading cause of deaths for children of all ages is injury, specifically deaths due to motor vehicle crashes, which accounted for 5.8 deaths per 100,000 children aged 1-14 years. Continued efforts are needed to address this public health concern and to create opportunities for prevention. Deaths due to injury, such as motor vehicle crashes, drowning, and fires and burns, are, for the most part, preventable. Other leading causes of death among Texas children that are less likely to be preventable include birth defects, malignant neoplasms, and heart diseases.

Fatal Unintentional Injury Rates From Motor Vehicles to ages 1-12 (children) and 13-19 (Adolescents). The motor vehicle mortality rates for both age groups, 1-12 and 13-19, experienced similar patterns. Both rates decreased in 1994 and 1995, increased in 1996, and then decreased in 1997 and 1998. Data also reveal that death rates due motor vehicle crashes among both age groups are higher than the U.S. average.



In 1998, Texas residents aged 1-12 years had 203 fatalities from motor vehicle accidents with a death rate of 5.3 per 100,000. While every person is at risk for injury, certain populations in terms of age, race and ethnicity appear to be affected more frequently. The rate for African American children (9.0 per 100,000) was more than twice that of White children (4.1 per 100,000). Another disparity showed that children aged 1-4 years (6.1) were more likely to die from motor vehicle crashes than children aged 5-9 years (4.2) and 10-12 years (5.9). In contrast, African American children between the ages of 13 and 19 accounted for only 42 of the 523 fatalities from motor vehicle accidents among children within the same age group. While the overall rate of death was 24.4, White adolescents accounted for the highest rate of 27.1 per 100,000, followed by Hispanics at 24.9 and African Americans at 15.2. Moreover, the likelihood of death due motor vehicle crashes increased with the adolescent ages. Adolescents aged 13-14 years had the lowest motor vehicle death rate of 8.7 per 100,000, followed by adolescents aged 15-16 years at 22.1 per 100,000. Adolescents aged 17-18 years were third at 35.4 per 100,000 and 19 years old were highest at 35.6 per 100,000. Motor vehicle crashes still remain a major challenge for Texas. More efforts are needed to educate parents, schools, children and adolescents on the use of age-appropriate restraint systems and traffic and safety information.

Child Abuse and/or Neglect For Ages 0-15. The rate of confirmed victims of child abuse and/or neglect for children younger than 18 years has decreased in Texas and the U.S. from 1994 through 1997. However, the Texas rate rose from 7.5 per 1,000 children in 1997 to 8.1 in 1998. The graph below shows that Texas rates are consistently lower than the U.S. averages.

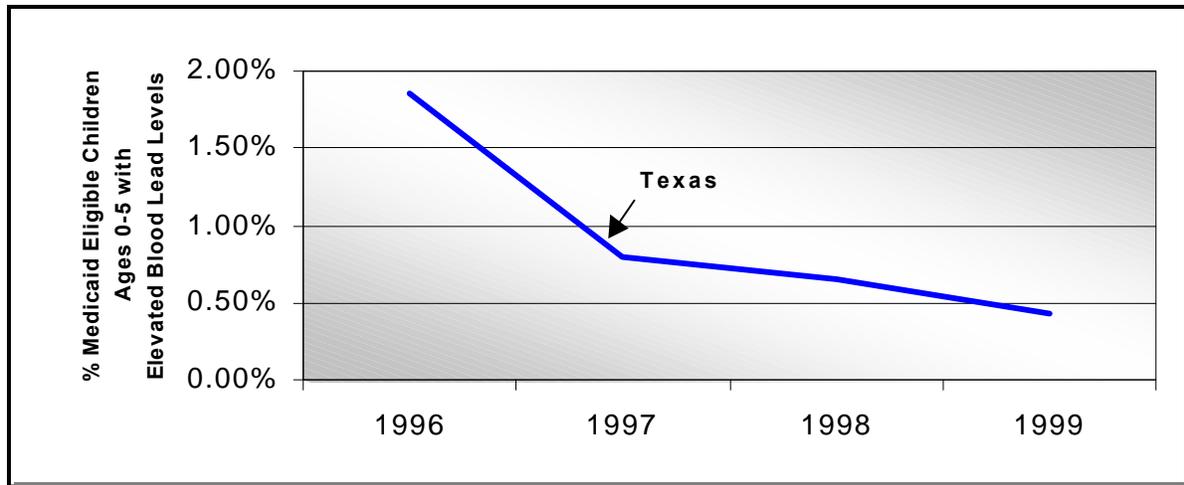


Data indicates that there is no racial and ethnic disparities in the occurrence of the 41,439 confirmed victims of child abuse and/or neglect among children under 15 years in 1998. White confirmed victims accounted for 15,781 cases (0.7%), followed by Hispanic and African American with 14,348 (0.7%) and 10,188 (0.6%), respectively. Data also show that infants had the highest percent of confirmed victims at 1.2%. Efforts are continued to reduce further the rate of maltreatment of children, which is already below the HP 2010 of 11.1 per 1,000 children under 18 years.

THSteps Checkups for Children 1-14. Children between 1 and 5 years in the Texas Medicaid program are expected to have 6 checkups during a 5-year period (1.2 per year), then 5 checkups from ages 6 to 14 years (5.6 per year). In 1999, the number of children expected to receive a checkup was 803,538. Of these, 446,175 or 56% received medical screens, which improved by 8% since 1997. Since the Texas Health Steps (THSteps) program transferred from the Texas Department of Human Services to Texas Department of Health/Associateship for Community Health and Resources Development in September, 1993, THSteps has implemented new policies and activities at both the regional and community levels. Activities include expanded outreach efforts and provider recruitment to promote uniform levels of screening across the 11 TDH public health regions. Currently, percentages of screening-eligible children vary from 42% in PHR 7 to 74% in PHR 11 (see below graph). Both Texas and the U.S. averages are far from meeting the Health Care Financing Administration of 80% participation for children aged 1-14 years and the HP 2010 objective of 95% participation.

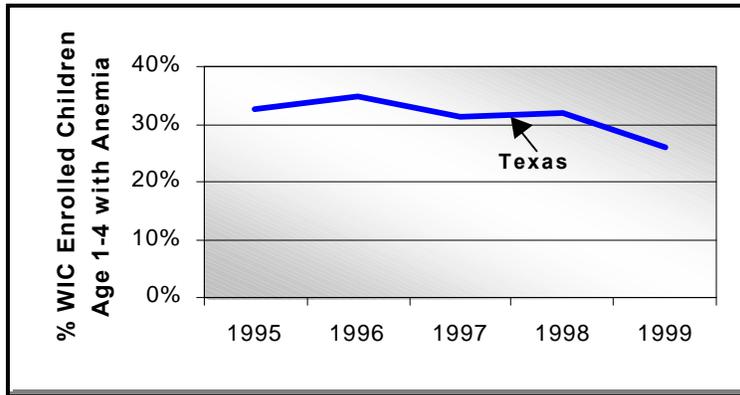
THSteps Dental Services. Children 1-14 years in the Texas Medicaid program are recommended to have two prophylactic dental exams each year, additional preventive treatments such as sealants, and treatments for dental problem (caries, etc.) as required. In 1999, of the 1,318,646 eligible children aged 1-14 years for THSteps program, 513,372 or 39% children received dental services. The number of children receiving dental services in Texas declined slightly from 557,364 in 1998 to 513,372 in 1999, a decrease from 40% to 39%. Nationally, the number of children receiving dental assessments (preventive exams and/or sealants) was 24.9% vs. 34.6% in Texas in 1997.

Elevated Blood Lead Levels. The percent of Medicaid eligible resident children aged 1 to 5 years with blood lead levels at or greater than 10 mg/dL was 0.43% in 1999, down from 1.85% in 1996. In 1998, there were 5,514 children aged 1-5 years screened for blood lead levels. Of these, 1,182 (0.87%) were African American children and 3,184 (0.70%) were Hispanics. Continued efforts are needed to educate parents, children and schools about the adverse effects of lead and to improve follow-ups and referrals for those who screened positive for high blood lead. Achieving the national target of 0 children with elevated blood lead by 2010 remains a concern.

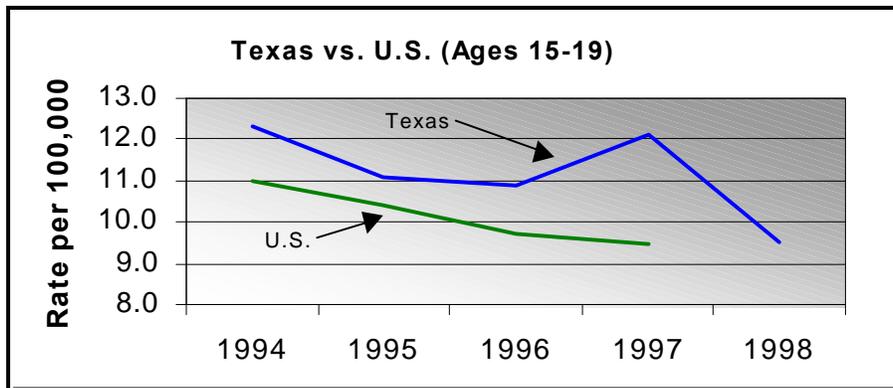


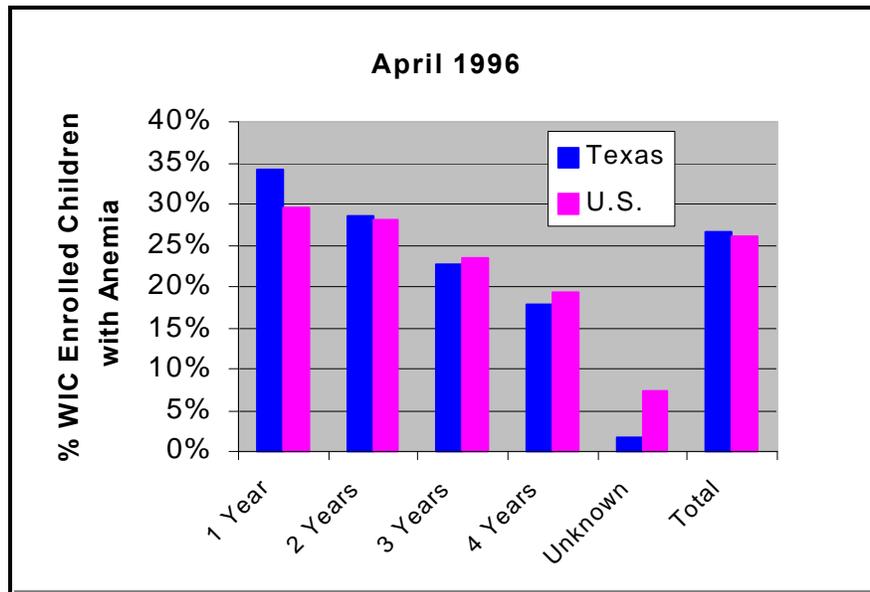
Anemia. Texas experienced a decrease from 32.49% in 1995 to 26.06% in 1999 in the number of WIC enrolled children aged 1 to 4 years with anemia (either Hct < 33.0% or Hgb < 11.0 g/dL for age 1 year and Hgb < 11.1 g/dL for age 2 to 4 years). As of April 1996 (latest available national data), the Texas percent of resident WIC enrollees aged 1-4 years with anemia (27%) was slightly higher than the national average (26%). Graphs below show 1) the Texas trends 1995-99 of WIC enrolled children aged 1-4 years with anemia and 2) a comparison between Texas and U.S average percentages of WIC enrolled children aged 1-4 years as of April, 1996.

Disparities for anemia cases in children are evident in many segments of the children population based on age, race and ethnicity. For example, African American anemic children contributed to a 29% of the total children aged 1- 4 years, compared to Hispanic and White anemic children with 26% and 23%, respectively. Furthermore, data show that Texas children ages between 1 and 2 years (29.55% and 31.41%, respectively) were more susceptible to anemia than their 3 - 4 years old counterparts (24.79%, 15.96%, respectively) .



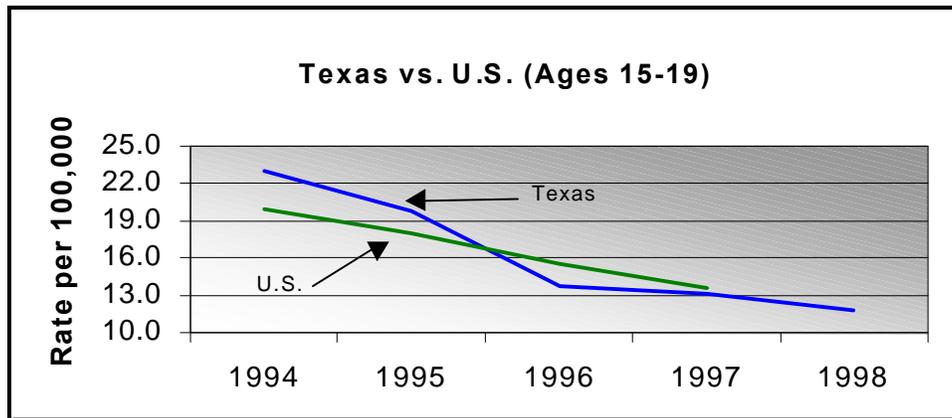
Suicide. In 1998, the suicide rates of Texas adolescents aged 13-19 and 15-19 years were 7.7 and 9.5 per 100,000 adolescents in each age group, respectively. This represents a decrease of 24.5% from 1994, when the rate per 100,000 adolescents aged 13-19 years was 10.2. However, for adolescents aged 15-19, Texas rates of suicide remained higher than U.S. averages between 1994 and 1997.





Data show that the suicide rate among White adolescents was 8.2 per 100,000 adolescents aged 13-19, followed by Hispanics and African Americans with 8.0 and 4.7, respectively. Additionally, the rate of suicide increased significantly with the age of the adolescent. The rates ranged from a low of 1.3 deaths per 100,000 for 13 years old to 12.1 deaths for 19 years old. Overall deaths of adolescents are more likely to be due to external causes than to congenital diseases. According to the current scientific knowledge, more than 50% of these leading external causes (i.e., motor vehicle crashes, homicide, suicide) are preventable. Therefore, reducing the 165 deaths due to suicide in Texas in 1998 requires individuals and communities to make healthy lifestyle choices. Above all, it also demands that local /statewide public and private programs and organizations, along with communities, work together, using both traditional and innovative approaches, to help Texan residents achieve the 10-year targets of reducing deaths of adolescents aged 10-14 years to 16.8 per 100,000 and 15-19 years to 43.2 per 100,000.

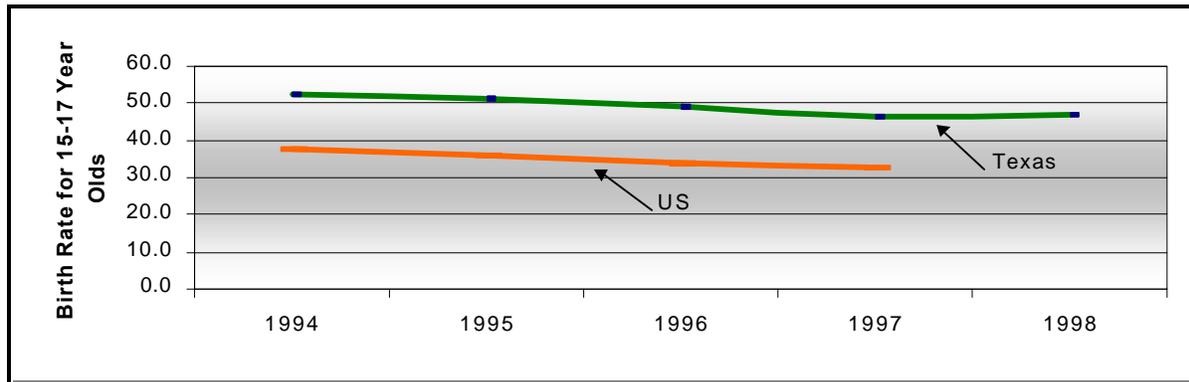
Homicide. The 1998 homicide rates of Texas adolescents aged 13-19 and 15 -19 years were 9.1 and 11.8 per 100,000 adolescents in each age group, respectively. This represents a decrease of 48.6% from 1994, when the rate of adolescents aged 13-19 years was 17.7 per 100,000. While the overall rates for homicide for all ages in Texas decreased between 1994 and 1998, they still remained higher than the U.S. averages.



Homicide was the cause of deaths for 196 adolescents aged 13-19 years in 1998. Homicide is the second leading cause of death for adolescents for the same age group and the leading cause of death for African Americans in this age group at 24.2 per 100,000 adolescents aged 13-19 years.

In 1998, the rate per 100,000 of deaths to adolescents ages 13-19 due to homicide was 9.1. African American (24.2) and Hispanic (12.8) adolescents had a higher rate of homicide than did White (3.4) adolescents. Additionally, the rate of homicide increased with the age of the individual. Of all 196 homicide victims in 1998, 93% were between 15 and 19 years. Moreover, the rates ranged from a low of 0.7 deaths per 100,000 for 13 years old to 19.3 deaths for 19 years old. Currently, there has been a concerted effort and commitment to put potentially effective intervention strategies for violence prevention into practice. These strategies for reducing violence have a common understanding that the implementation should begin early in life before violent beliefs and behavioral patterns can be adopted. Achieving the national target of 3.2 homicides per 100,000 population remains a challenge for Texas.

Teen Pregnancy. In 1998, the pregnancy rate to females aged 15-17 years was 47.1 per 1,000 and teen pregnancies to females aged 13-17 accounted for 6.4% of all pregnancies and 6.4% of all live births in Texas. Births to 15-17 years old in Texas and the U.S. declined by 11% and 13% from 1994 to 1997, respectively. In 1997, births to this age group were 42% higher in Texas than in the U.S. average.



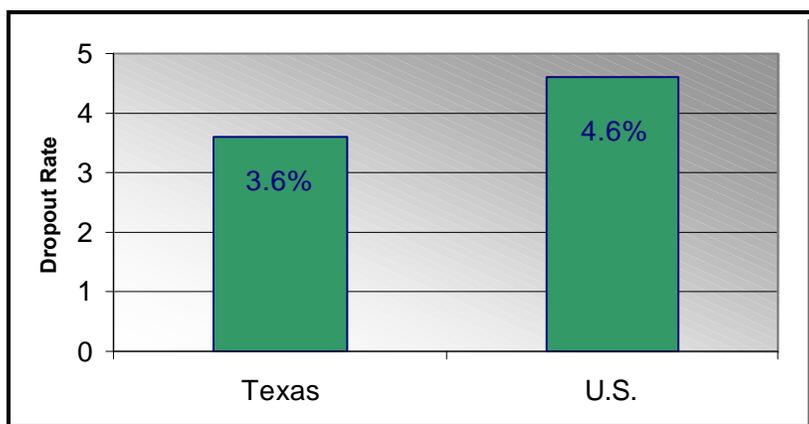
Disparities for pregnancy in females aged 13-17 years are evident in many segments of the adolescent population's age, race and ethnicity. Hispanic (58.7) and African American (48.2) females aged 13-17 years rates were each more than twice of that White (19.3) teenagers. Furthermore, the rate of teen pregnancy increased with the teenager's age. Of all 26,627 teen pregnancies in 1998, more than 80% were pregnancies to females aged 16 and 17 years. Moreover, the rates ranged from a low of 1.7 live births per 100,000 for 13 years old to 90 live births for 17 years old.

Teen pregnancy remains an intense statewide issue within the context of public health and welfare. Teenage mothers are less likely to complete high school or college and more likely to require public assistance and to live in poverty than their peers who are not mothers. Additionally, infants born to teenage mothers are more likely to suffer from LBW and neonatal death. Infants may be at greater risk of child abuse, neglect, and behavioral and educational problems at later stages. Despite a consensus among health and human services leaders at both state and local levels, that all pregnancies in this age group are inappropriate and that the target should be zero, 26,627 teen pregnancies occurred in Texas in 1998. Currently, Texas Title V program is addressing the problem on two fronts: 1) Focusing on public education and information about family planning that need to be expanded. Public education efforts could help individuals to understand better the benefits of sexual abstinence; and 2) Continuing the provision of quality family planning services for promoting healthy pregnancies and preventing unintended pregnancies.

STDs - Chlamydia. While the overall rates for chlamydia for Texas women for all ages decreased between 1994 and 1996, they increased in both 1997 and 1998, ending with a rate of 5.1 per 1,000 women. For women aged 15-19 years, the rates of chlamydia infection fluctuated in similar trends to that of women for all ages and accounted for a rate of 28.4 per 1,000 in 1998. This represents an increase of 18.8% from 1994, when the rate per 1,000 women was 23.9. Furthermore, rates of chlamydia for Texas women were consistently higher than the U.S. average rates.

Although chlamydia is found in all population groups, it occurs more frequently in certain racial and ethnic groups. Hispanic persons accounted for about 30% of the total number of reported cases of chlamydia, nearly twice the rate in White teenagers. Additionally, chlamydia rates in African Americans were 1.6 times the rate of Whites. Concerning age disparities, for a variety

of behavioral, social, and biological reasons, chlamydia disproportionately affects adolescents. In other words, the rate of chlamydia infection increased with the woman's age. The rate of infection for women between 15-19 years old ranged from a low of 13.7 cases per 1,000 for 15 years old to a high of 34.6 cases per 1,000 for 19 years old. In order to reduce cases of chlamydia infections and other STDs among teenagers, Title V and other related-programs within TDH should focus on preventing the disproportionate effect that STDs have on Hispanic and African American populations; apply proven, cost-effective behavioral interventions; and recognize that education and health care infrastructure policies must foster change in personal behaviors and in health care services. Behavioral interventions cover a wide range of purposes, for example, to help teens to abstain from sexual intercourse, delay initiation of intercourse, reduce the number of sex partners, and increase the use of condoms.



School Dropouts - Adolescents, Grades 7-12. Comparison dropout rates were obtained from the National Center for Education Statistics (NCES). Texas had a national comparison dropout rate of 3.6% for adolescents in grades 7-12 in 1998. This rate was higher than the reported state rate of 1.6%, primarily due to differences in the dropout definitions and methodologies used by NCES and the state of Texas. In 1998, the overall dropout rate for the U.S., as calculated by NCES, was

4.6%.

In 1998, the dropout rate for adolescents in grades 7 through 12 was 1.6%. This represents a decrease of 38% from 1994, when the dropout rate was 2.6%. Racial and ethnic disparities for dropouts in adolescents in 7-12 grades are evident. Hispanic youth had accounted for the highest dropout rate of 2.3%, nearly 3 times the rate in White adolescents (0.9%). Similarly, dropout rate in African Americans (2.1%) was more than twice the rate of Whites. Furthermore, the dropout rate for 10 years old with 2.6% in 1998 was higher than those of students aged between 12 and 16 years. Of the highest rates were among 19 years old (11.4%) and 20 years old (13.0%). Data presents a challenge Texas to eliminate racial and ethnic dropout disparities and, in turn, reduce the gap in high school graduation rates of minority students. The challenge will be even greater due to the rapid change in the composition of the Texas population over the next decade that will become more racially and ethnically diverse. Thereby, the urgency of increased effective prevention programs tailored to specific community needs are needed.

State-level needs assessment projects that confirm current health issues, risk behaviors and personal safety among children and adolescents in Texas.

1999 Texas Youth Risk Behavior Survey Results. The survey was administered to nearly 1,800 students attending 16 of 33 selected public high schools (grades 9-12). Because of poor

school response, the data could not be weighted to reflect the public high school population in the state of Texas. Data presented are, therefore, not representative and only reflect those who took the survey.

I. VIOLENCE-RELATED BEHAVIORS

Percentage of high school students who carried a weapon or gun in the past 30 days

Carried a weapon	21.2%
Carried a gun	7.7%

Percentage of high school students who carried a weapon on school property during the past 30 days

Carried a weapon on school property	11.5%
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Percentage of high school students who felt unsafe at school or on the way to and from school during the past 30 days

Felt unsafe to go to school	10.0%
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Percentage of high school students who were threatened or injured with a weapon on school property during the past 12 months

Threatened or injured with a weapon	9.9%
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Percentage of high school students in a physical fight during the past 12 months

In a physical fight	34.0%
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Percentage of high school students injured in a physical fight which had to be treated by a doctor or a nurse during the past 12 months

Injured in a physical fight	4.5%
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Percentage of high school students in a physical fight on school property during the past 12 months

In a physical fight on school property	11.8%
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Percentage of high school students who reported to have been physically hurt by boyfriend or girlfriend during the past 12 months

Hurt physically by boyfriend/girlfriend	15.6%
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Percentage of high school students who reported to have been forced to have sexual

intercourse

Was forced to have sexual intercourse	13.0%
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II. PERSONAL SAFETY QUESTIONSPercentage of high school students who reported wearing a helmet while riding a motorcycle during the past 12 months

Rarely or never wore a helmet	54.0%
Sometimes wore a helmet	11.4%
Most of the time or always wore a helmet	34.6%

Percentage of high school students who reported wearing a helmet while riding a bicycle during the past 12 months

Rarely or never wore a helmet	93.6%
Sometimes wore a helmet	2.9%
Most of the time or always wore a helmet	3.5%

Percentage of high school students who reported wearing a seat belt when riding in a car driven by someone else

Rarely or never wore a seat belt	9.8%
Sometimes wore a seat belt	12.4%
Most of the time or always wore a seat belt	77.8%

Percentage of high school students who reported riding in a car or other vehicle driven by someone who had been drinking alcohol

Rode with a driver who had been drinking alcohol	
at least one time	44.5%
0 times	55.5%

Percentage of high school students who reported driving a car or other vehicle after drinking alcohol

Driving after drinking alcohol	
at least one time	23.6%
0 times	76.4%

III. OTHER RISK BEHAVIORSPercentage of Students who:

Attempted suicide during the past 12 months	7.2%
Smoked cigarettes during the past 30 days	36.9%
Drank alcohol during the past 30 days	54.5%
Used marijuana during the past 30 days	22.3%

Water Fluoridation. The Texas 75th Legislature passed House Concurrent Resolution 145 requiring TDH to conduct a study of the cost of publicly financed dental care in relation to community water fluoridation.

The study assessed the impact of one public program for prevention of tooth decay, community water fluoridation, on another program, Medicaid, which provides publicly-funded dental care for a group known to be at great risk for oral diseases. The median water fluoride level was calculated for each county, weighted by population, and compared with the claims paid to dentists in FY 1997 for treatment of children aged 1-20 years and enrolled in the Texas Health Steps (THSteps) program (formerly EPSDT). Over 80% of the THSteps costs were related to examination, prevention, and treatment of tooth decay.

Statistical analysis of dental care costs and county water fluoride levels showed that for an initial one part per million rise in water fluoride level (from 0.0 to 1.0 ppm fluoride), the average cost of dental care per child declined \$24 per year. This estimated cost savings in public dental care could be realized if water fluoridation was provided in communities with less than optimal water fluoride levels. Approximately, 30% of Texas residents currently experience less than optimal levels. These findings are consistent with national studies which report a reduction in childhood caries in communities with optimal water fluoridation levels.

The wide implementation of community water fluoridation in Texas has resulted in substantial savings in publicly-financed dental care under the THSteps program. Further savings may be realized by implementing community water fluoridation in areas where it is lacking, when feasible.

Dental Health. In FY 95, the Bureau of Dental Health Services (BDHS) staff conducted a statewide dental health survey of children in grades 2 and 10 in Texas. The project included student questionnaires and visual dental examinations for tooth decay and general oral health by dentists. BDHS surveyed a total of 1,809 students: 1,099 in grade 2, representing a 76% response rate, and 710 in grade 10, with a 49% response rate.

Table 8 below displays weighted dental health survey results as related to selected Healthy People 2000 objectives and a 1986-87 national baseline. The data show that Texas schoolchildren have substantially higher percentages of both treated/untreated caries and unrelated dental infections than Healthy People 200 objectives 13.1 and 13.2. Compared to the national baseline, Texas 15 years old have lower rates of treated/untreated caries (73%) than U.S. 15 years old (78%).

The results also show that Texas has a substantially lower percentage of children who have received protective sealants than Healthy People 2000 objective 13.8. However, both age groups of Texas schoolchildren have higher percentages of sealants than the national

baseline groups. Overall, the School Dental Health Survey provided valuable information that confirms the need to promote preventative dental health practices including good oral hygiene and use of dental sealants as strategies to achieve the Healthy People 2000 objectives. Consequently, in FY 1999, the oral Health Division (formerly BDHS) proposed a state performance measure to lower the prevalence of caries among children.

Health Indicator	National Baseline 1986-87	Texas 1994	H.P. 2000 Objectives
Percent of Texas Schoolchildren with Treated/Untreated Caries [H.P. 13.1]			
6 - 8 years	53%	67%	35%
15 years	78%	73%	60%
Percent of Texas Schoolchildren with Untreated Caries [H.P. 13.2]			
6 - 8 years	27%	43%	20%
15 years	23%	45%	15%
Percent of Texas Schoolchildren Receiving Protective Sealants [H.P. 13.8]			
6 - 8 years	11%	26%	50%
14 years*	8%	24%	50%

* Ages are one year off in Texas study, comparison is relative and should be very similar at one year interval

Child Obesity: In FY96, the Bureau of Nutrition Services (BNS) targeted child obesity as a major initiative due to the increasing prevalence rates documented in several studies. Results from the 1994 Nutrition Education and Training Needs Assessment conducted in Texas school children showed that 25% of students of all ages were obese. The 1993 Texas Youth Risk Behavior Survey indicated that 24.4% of all adolescent males and 41.7% of all adolescent females believed they were overweight. Finally, the Report on Nutrition Monitoring in the United States (December, 1995) showed that the prevalence of overweight among children and adolescents increased from 5 % in the 1960s to 11% in 1988-91. Based on these findings, BNS developed a state performance measure related to child obesity in FY 1999.

Children with Special Health Care Needs

A significant number of children in Texas have chronic, activity-limiting conditions. The Title V Children with Special Health Care Needs (CSHCN) Program has taken several different approaches to gathering and recording information to assess and describe the extent of health problems for CSHCN. The first approach includes projections based on results from the National Health Interview Survey (NHIS). The second approach is the certificate of live birth, which contains crucial health status indicators, including whether a newborn is born with a congenital anomaly or birth defect and/or a very low birth weight. The third and fourth approaches are asthma prevalence and private duty nursing, respectively. The fifth approach is the number of children on Supplemental Security Income (SSI). The last approach to gather additional information to identify the extent of CSHCN population is the number of CSHCN enrolled in special education.

National Health Interview Survey (NHIS). NHIS data indicate that during 1999 there were approximately 294,929 children who either had a chronic illness with special needs or were limited in the amount of major activity due to one or more conditions. To arrive at this estimate, a 9% prevalence estimate has been applied to the 1999 projected Texas children aged 0-21 at 200% FPL. When applying NHIS prevalence estimates, it is important to note there may be biases and limitations in the data insofar as Texas differs from the nation in various determinants, including demographics.

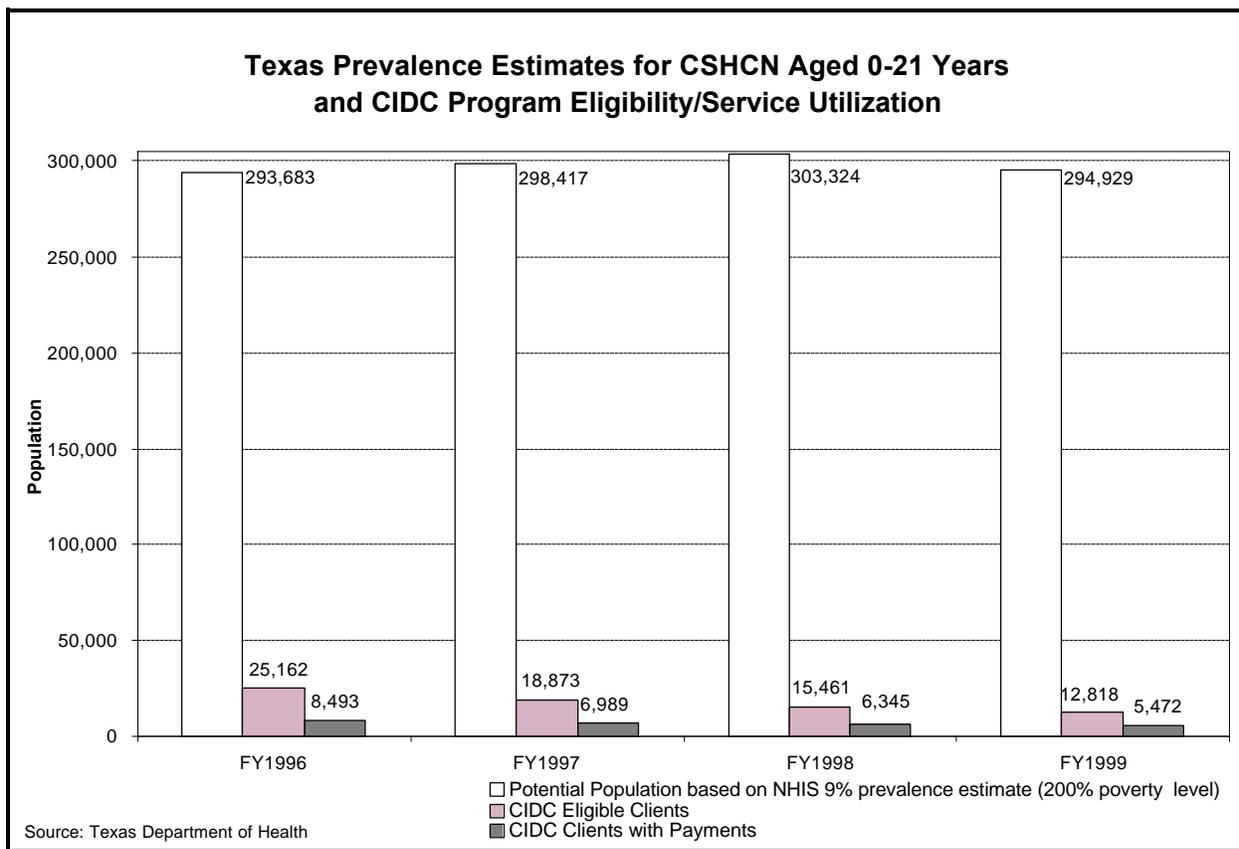


Figure 1

Figure 1 above compares Texas' prevalence estimates of the number of CSHCN with service data for the state Title V CSHCN program. Between 1996 and 1999, data indicate that the CSHCN program provided services to a small percentage of the estimated number of children who may qualify for services and that the program is serving fewer of the children-in-need over time. Figure 1 shows that in 1999 the CSHCN program determined that 12,818 children were eligible for services and paid claims for 5,472 children, while 294,929 children aged 0-21 years may potentially have been eligible for services. Of the estimated 294,929 CSHCN in Texas at 200%FPL, a large percentage have Medicaid and some have private insurance or Texas Healthy Kids. The CSHCN program covers only children with a certain diagnoses, not all CSHCN. Of the 12,818 eligible-CSHCN, about 32% have Medicaid all or part of the year and 14% have private insurance. The CSHCN program does not pay service claims that are payable by Medicaid or private insurance. Therefore, some children on the CSHCN program have no paid claims. The decrease in the numbers of children eligible for services and those with claims paid from 1996 to 1999 is a direct result of Medicaid expansions and the requirement that families of CSHCN must apply for Medicaid benefits first.

It is important to note that the CSHCN program provides case management / care coordination services for about 45,000 children on a yearly basis, most of whom do not have paid claims. In addition, since 1989, the CSHCN program's role has changed from providing a source of health care coverage to undertaking more systems development. The CSHCN program is serving fewer children through direct services and affecting more children's lives through its involvement in Medicaid policy, its development of systems of care, and its aggressive efforts to assure that all eligible-children are enrolled in, and their services are paid by, the appropriate resource. As CSHCN currently receiving direct medical care through the Title V CSHCN program move into CHIP, the program will be able to remove restrictive diagnosis limitations and serve additional children whose needs are not being met through CHIP, Medicaid, or the private insurance sector. Consequently, as mandated by SB 374 of the 76th Texas Legislature, the state Title V CSHCN program is gradually going through major changes. The program staff are working on changing the definition of CSHCN used for program eligibility from a limited definition based on medical diagnoses to a much broader functional definition of chronic illness and disability; designing a program to provide CSHCN with access to a health care benefits plan similar in scope to CHIP and offering an expansive array of family support services for eligible CSHCN.

Birth certificate (congenital anomaly or birth defect). In 1995, 916 cases of births defects were detected among live born infants and fetuses of 20 or more weeks gestation delivered to mothers residing in PHR 6 and PHR 11 (area covered by TDH Birth Defects Registry Monitoring) (Appendix D).

Prevalence of Select Births Defects - 1995

Birth Defect	Number of Cases
Central Nervous System	207
Cardiovascular & Respiratory	109
Oral Clefts	177
Gastrointestinal	84
Genitourinary	56
Musculoskeletal	116
Chromosomal	165
Other	2

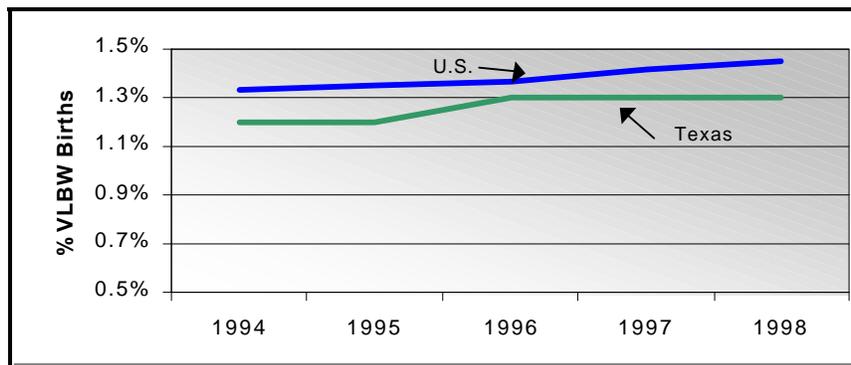
Source:
 TDH, Bureau of Epidemiology, Texas Birth Defects Registry
 Report of Births Defects Among 1995 Deliveries

Surveillance was limited to approximately 23 major categories of birth defects, comprising 30%-40% of all known structural malformations. Down's Syndrome, oral clefts, and spina bifida were the most commonly occurring birth defects. Anencephaly and spina bifida were lowest among African Americans, while among Whites and Hispanics the rates were similar. Cleft palate was more likely to occur among Whites and Hispanics. Rates for Trisomy 18 (Edwards Syndrome) were highest among African Americans and Whites.

Birth certificate (very low birth weight births). Of all infants, those born at very low birth weight (VLBW) are at the highest risk of dying in their first year. Moreover, VLBW infants who survive

Table 9

their first year are more likely to experience long-term developmental and neurologic disabilities than are infants of normal birth weight. The percent of very low birth weight (VLBW) births has increased slightly in Texas and in the U.S. from 1994 to 1998 (Appendix D). However, in 1998, data indicate that 1.3% of all live births to Texas residents were VLBW births, compared to 1.5% nationwide.



The 1998 Texas proportion of VLBW births represents an increase of 8.3% from 1994, when 1.2% of live births were VLBW. Similar to LBW births, the increase in VLBW births is due in great part to the high occurrence of multiple births in recent years. Furthermore, the likelihood of giving birth to a newborn with VLBW was greater among African American mothers with a rate of 2.4%. The risks of giving birth to a VLBW infant were 0.8% and 0.9% among White and Hispanic mothers, respectively.

Asthma Prevalence. In 1999, among the 1,766,010 THSteps-eligible children, 86,888 children

were diagnosed with asthma, representing a 4.9% prevalence rate (Appendix D). Another source of information to estimate the number of children who may be diagnosed with asthma is to apply the Gortmacher Factor (asthma: .01) to the total population of children ages 0-21 years (1999 estimated total population of children: 6,827,060). Using Gormatcher Factor, there were 68,271 children with asthma in Texas.

Children on Supplemental Security Income(SSI). Another source of information used to identify the extent of CSHCN population is the number of children on Supplemental Security Income(SSI).

Special Education. Another indicator to assess the extent of CSHCN populations is the Texas Department of Education’s individuals with disabilities. In school year 1998-99, there were 472,627 students enrolled in special education (Appendix D). Of these, 264,771, or 56%, were students with learning disability and 90,222, or 19%, were students with speech impairment. The disability breakdown was based on primary diagnoses.

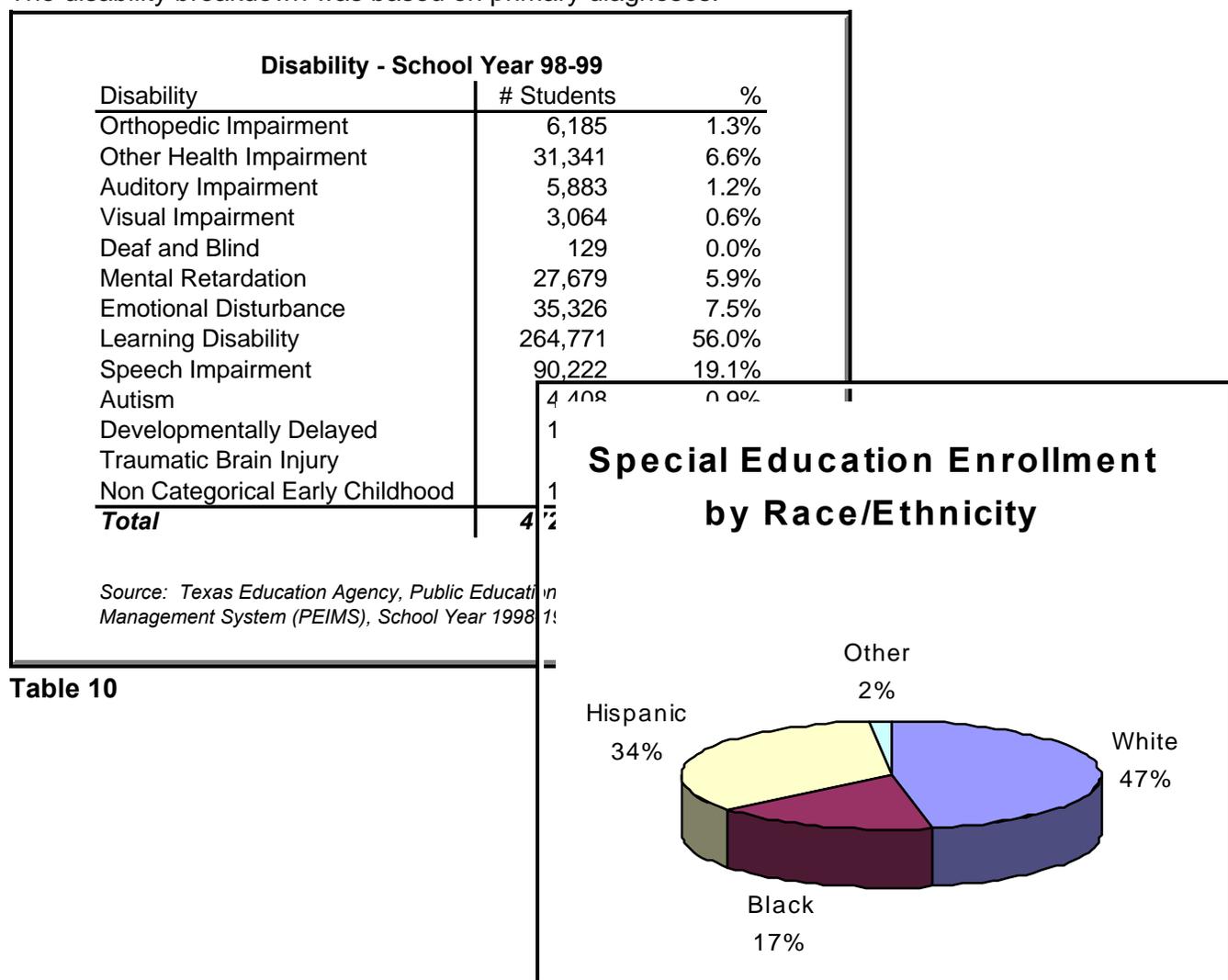


Table 10

Source: Texas Education Agency, Public Education Information Management System (PEIMS), School Year 1998-1999

Source: Texas Education Agency, Public Education Information Management System (PEIMS), School Year 1998-1999

Furthermore, the racial/ethnic makeup of students receiving special education services was very similar to those of both school age and the general population in Texas.

Table 11

Summary of State-Level Needs Assessment Projects for CSHCN that Support Systems Development For Enhancing the Ability of CSHCN to Live and Receive Services in Their Communities.

Data Source	Summary of Findings / Results
<p>The United Way of Texas, Regional Councils of Texas, Health and Human Services Commission (HHSC) and 12 Health and Human services state agencies.</p> <p>Local United Ways and Councils of Government organized the forums at the community level. The purpose of the forums were: 1) to improve the delivery of state-funded health and human services in Texas and 2) to involve stakeholders, consumers and local community leaders in developing the next Health and Human Services Coordinated Strategic Plan. Twenty-one forums were held.</p>	<p><u>Expand opportunities for community-based services.</u> HHSC is directed by the Governor’s Office to take the lead in implementing a Promoting Independence Initiative to assure that the state moves deliberately and decisively toward a system of services and supports that fosters independence and provides meaningful opportunities for persons with disabilities to live a productive lives in their home communities, for those who choose to do so. To this end, a twelve-member advisory board has been appointed by and will report to the HHSC Commissioner. This advisory board is comprised of seven consumer/family representatives, three representatives of service providers, and two agency board members.</p> <p><u>Expand the availability of respite services.</u> Currently, access to respite services is difficult for a variety of reasons. Funding for services is minimal and some waiver programs are not available statewide. Waiting lists to access respite care are long. In addition, respite services are delivered through a fragmented service delivery system that often leaves families without providers. There is a need for better coordination and collaboration among agencies in the delivery of respite services.</p>

<p>Texas Department of Mental Health/ Mental Retardation (MHMR), In-Home and Family Support Program (IHFSP), Service Utilization for Ages 0-21 in FY 1999</p> <p><u>Voices Represented</u></p> <ul style="list-style-type: none"> • IHFSP participants, defined as: <ul style="list-style-type: none"> • ages 0-21 • substantially impaired by mental illness or pervasive developmental disorder • ages 0-4 with developmental delay • diagnosis of MR • range of income levels; co-pay if over 105% of Texas median income (approximately \$50,000 for a family of four) 	<ul style="list-style-type: none"> • Service utilization, in order from greatest to least, was as follows for FY 1999: <ol style="list-style-type: none"> 1. respite (2162), 2. health services (1919), 3. special equipment<\$600 (575), 4. training/counseling (536), 5. services to support inclusion in community activities (501), 6. home care (488), 7. transportation (271), 8. “non-renewable” services (237), 9. one-time home modifications<\$3600 (143), 10. one-time special equipment <\$3600 (142), 11. home modifications<\$600 (107). • Respite and health services were by far the most heavily utilized services, with 3-4 times higher utilization than the next highest services.
<p>“Consumer Participation in ECI’s FY 1999-2000 Planning Process,” 1999</p> <p><u>Voices Represented</u></p> <ul style="list-style-type: none"> • babies or toddlers with disabilities or developmental delays • all income levels 	<ul style="list-style-type: none"> • The 76th Legislature funded respite services to be delivered through Early Childhood Intervention (ECI). • ECI families have expressed that respite will be especially helpful for them when they need: <ol style="list-style-type: none"> 1. To have a break from caring for a child for whom normal child care is not an option; 2. To attend to other family needs; and 3. To obtain safe care for their child while the caregiver goes into the hospital or assists another family member in the hospital.

<p>Medically Dependent Children Program survey regarding most important Medicaid waiver services, 1999</p> <p><u>Voices Represented</u></p> <ul style="list-style-type: none"> • families with children who meet medical necessity criteria for admission to a nursing facility • all income levels • more than half are eligible for SSI 	<ul style="list-style-type: none"> • Respite is considered the most important waiver service by almost 100% of participants. <p>(from program data, over 1,000 children are enrolled in MDCP and may receive respite services, an increase of 67% since 1996)</p>
<p>“Priorities of Local Mental Retardation Authorities: Statewide Summary Report,” December 1999 Texas Respite Resource Network</p>	<ul style="list-style-type: none"> • Three <u>population groups</u> to which local MR authorities would target new funds: <ol style="list-style-type: none"> 1. Children and adolescents 2. Persons with severe health, dental, or behavioral problems 3. Persons with multiple disabilities, including dual diagnoses • Three <u>services</u> to which local MR authorities would target new funds: <ol style="list-style-type: none"> 1. Training and support services 2. Vocational/competitive employment services 3. Respite services

<p>“TXMH/MR Permanency Planning: Impact and Cost Analysis Final Report,” Nancy A. Rosenau, July 1996</p> <p><u>Voices Represented</u></p> <ul style="list-style-type: none"> • all sites in the state that participated in permanency planning training • parents of children with disabilities, including children currently in long-term placement • case managers • state agency staff • advocates 	<p><u>Findings:</u></p> <ul style="list-style-type: none"> • Support mechanisms should be family-centered. • Supports are not the same thing as services. • Families with CSHCN desire a system that they can depend on. • Families with CSHCN need help to do ordinary things. <p><u>Conclusions:</u></p> <ul style="list-style-type: none"> • Both families and children with disabilities experience changes for the better when they receive family support. • Children are more likely to be able to stay with a family if the family is supported. • Permanency planning has been confused with family support. Children with disabilities remain at risk because permanency has not been aggressively sought. <p><u>Recommendations:</u></p> <ul style="list-style-type: none"> • Expand family support efforts. • Develop alternate families. • Take control of entry and exit of residential alternatives.
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<p>TDH respite grants family satisfaction survey, 1995</p> <p><u>Voices Represented:</u></p> <ul style="list-style-type: none"> • Families who received respite services from October 1994 to July 1995 through TDH respite grants. • Model served families with various incomes using a sliding scale. • There were 114 respondents with a total of 143 children with disabilities. • Children's top five conditions ranked in order: <ol style="list-style-type: none"> 1) Developmentally delayed 2) Behavioral/emotional disability 3) Neurological/orthopedic disability 4) Mental retardation 5) Sensory disability (e.g., visually impaired) 	<ul style="list-style-type: none"> • TDH was the recipient of federal respite grants from the Administration on Children, Youth, and Families. These grants concluded in 1998. • Participating families were surveyed in 1995. • Types of respite used most often: <ol style="list-style-type: none"> 1. In-home 2. Special camps 3. Host families • Respite services are most helpful when: <ol style="list-style-type: none"> 1. Provided overnight 2. Available as special camps 3. Provided after school hours
<p>Texas Advocates Supporting Kids with Disabilities (TASK) Summit, October 1999</p> <p><u>Voices Represented:</u></p> <ul style="list-style-type: none"> • Approximately 40 participants from around the state, including parents of CSHCN, providers, and advocates. 	<ul style="list-style-type: none"> • Priorities identified at the TASK Summit: <ol style="list-style-type: none"> 1. Flexible funding 2. Parent training 3. Accountability and monitoring

<p>“On the Right Track” focus group results, 1998. The purpose of the “On the Right Track” grant from the U.S. Centers for Disease Control is the prevention of secondary conditions among people with disabilities.</p> <p><u>Voices Represented:</u></p> <ul style="list-style-type: none"> • Consumers and family members from 10 different communities in Texas • Professional service providers in two locations • Total participants 118 <ul style="list-style-type: none"> • Consumers/Family Members--95 • Professional Service Providers--23 	<ul style="list-style-type: none"> • TDH contracted with the University Affiliated Program (UAP) at the University of Texas at Austin to do focus groups with consumers and providers. • Dr. Mary McCarthy from the UAP asked participants: “What do you need to help you manage your life?” • <u>Key findings:</u> <ol style="list-style-type: none"> 1. Consumers/families experience the service delivery system as a “qualifying game” in which the rules are complex and are always changing. 2. There is a “clash of cultures” when consumers and families meet with medical or educational professionals. 3. Consumers and families need a “person who cares” to help them navigate the system, succeed at the qualifying game, and bridge the gap between the clash of cultures.
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<p>“Families Are Valued” workshops, August 1999</p> <p><u>Voices Represented:</u></p> <ul style="list-style-type: none"> • TDH collaborated with the Health and Human Services Commission (HHSC) and the Texas Council on Developmental Disabilities (TCDD) to convene three of the “Families Are Valued” project sites (in El Paso, Amarillo, and Austin), which are building capacity for permanency planning in their communities. • 40-60 participants (parents and providers) attended each meeting. 	<ul style="list-style-type: none"> • Summary/ highlights of needs identified: <ol style="list-style-type: none"> 1. Services that are available for middle-income families 2. Services for non-citizens 3. Respite care 4. Child care, including child care for children ages 12-18 5. Information and referral 6. Training for parents and professionals
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3.1.2.2 Direct Health Care Services

Pregnant Women, Women of Childbearing Age, and Infants

Population-in-need and clients served

Medicaid pays for all pregnant women with incomes below 185% of the federal poverty level (FPL). This excludes undocumented aliens who are eligible for delivery but not for prenatal care. It is estimated that there are approximately 26,396 undocumented aliens in need of prenatal care services. Since Medicaid meets most of the estimated need for obstetric services, Title V fills the gap in services by providing prenatal care services to undocumented aliens.

Under Medicaid, non-pregnant women are only eligible for up to 17% of FPL except for postpartum women who are eligible at 185% of FPL. Texas Title V program defines family planning population-in-need as all women ages 19-44 under 185% of FPL minus the number of women below 50% of FPL, plus 50% of adolescents ages 13-18 under 185% of FPL minus the number of women ages 13-18 below 50% of FPL plus 25% of adolescents ages 13-18 over 185% of FPL. Title V estimates that there are more than 1.2 million or 27% of women and adolescents, potentially in need of publicly-funded family planning services in the state.

Title V prenatal clinics provided care to approximately 56,109 unduplicated clients in FY 99. These clients received a total of 234,952 visits for an average of 4 visits per client. FY 98 Medicaid claims data show that payments were made to Title V prenatal providers for 16,389 clients and 62,825 visits. This represents payment for approximately 29% of prenatal clients and 27% of visits, and \$1,609,219 in earned income.

Title V family planning clinics provided care to approximately 68,112 unduplicated clients in FY 1999. These clients received a total of 107,353 visits with an average of 2 visits per client. FY 1998 Medicaid claims data show that payments were made to Title V family planning provider agencies for 34,875 clients and 291,511 visits/services. This represents payment for approximately 51% of the clients and \$2,723,676 in earned income.

Children and Adolescents

Population-in-need and clients served

It is estimated that there are more 1.6 million children ages 0-21 in need of child health services at 185% of FPL.

Title V child health clinics provided preventive and comprehensive care to approximately 38,115 unduplicated clients ages 0-21 in FY 99. These clients received a total of 68,334 visits for an average of 2 visits per client. Texas Medicaid plays a very important role in children's health care. In 1998, Medicaid claims data show that payments were made to Title V child health provider agencies for 67,747 clients and 115,510 visits. This represents payment for more than \$3,878,069 in earned income.

Children with Special Health Care Needs

Population-in-need and clients served

As indicated in Section 3.2.2.1, there were approximately 294,929 children in need of primary and preventive care, specialty and sub-specialty care in 1999 (most of them have Medicaid and some have private insurance). During the same year, the state Title V CSHCN program served about 68,241 children through TDH regional offices, case management contractors, and private physicians and hospitals enrolled in the program. Examples of direct/enabling services provided now to eligible-children include physician visits, therapies, hospital stays, drugs, DME, medical supplies, meals, and transportation. Most of the 68,241 children received case management services.

In FY 99, the CSHCN Planning and Policy Division funded 17 case management/care coordination projects for \$2,104,483. Case management services were defined as "the assessment of a child's overall service needs, and the development and implementation of a course of action or plan for meeting those needs, which is family centered, community-based, culturally competent, comprehensive, and is intended to assist those clients who need a variety of services." Case management activities included information and education, needs assessment, mutual goal setting, referral services and agency liaison, coordination and follow-up, case monitoring, family empowerment, systems development, and advocacy.

Financial Barriers to Care for Title V populations

Health care access for women and children, including CSHCN, 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.

Unemployment, Income, and Poverty: Data indicate that Texas unemployment, as well in the rest of the nation, remains at an all time low and Texas statewide unemployment was 4.1% in February, 2000. 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-San Marcos, Bryan-College Station, Waco, Killeen-Temple) had the lowest unemployment rate. In contrast to the Rio Grande Valley (Laredo, Brownsville, Harlingen, Edinburg, Mission, McAllen), predominantly Hispanic, had the highest unemployment rate in Texas (see Figure 2). In 1997, Texas statewide average income per capita was \$23,707. Counties along the Texas-Mexico border area had the lowest income of less than \$15,000 (see Figure 3). As a result of the lowest income and highest unemployment rates, a large concentration of 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 1990, there were approximately 4.9 million children age 18 and under in Texas. They constituted 29% of the state's population. In 2030, they will represent 22.3% of the population, which will translate to 8.6 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 1998, 25.4% of all Texas children, compared to 21% 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 25% of the population ages 0-18 years in Texas were uninsured in 1999. 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. Figure 5 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, two million Texans live on the Texas-Mexico border with an estimated 375,000 border residents living in about 842 colonias that are predominantly Hispanic and sometimes lacking basic services such as water and wastewater. Of these two 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.

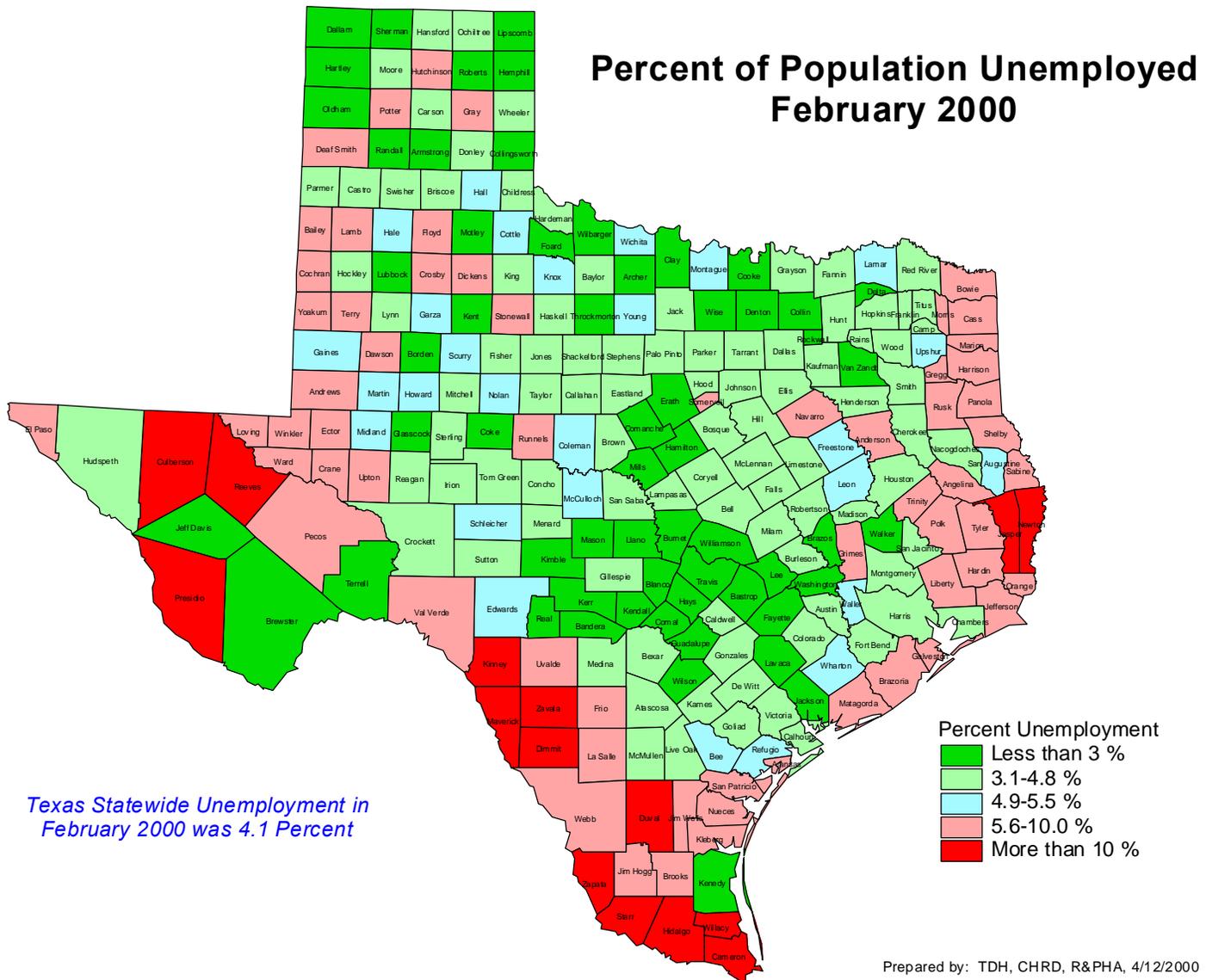


Figure 2

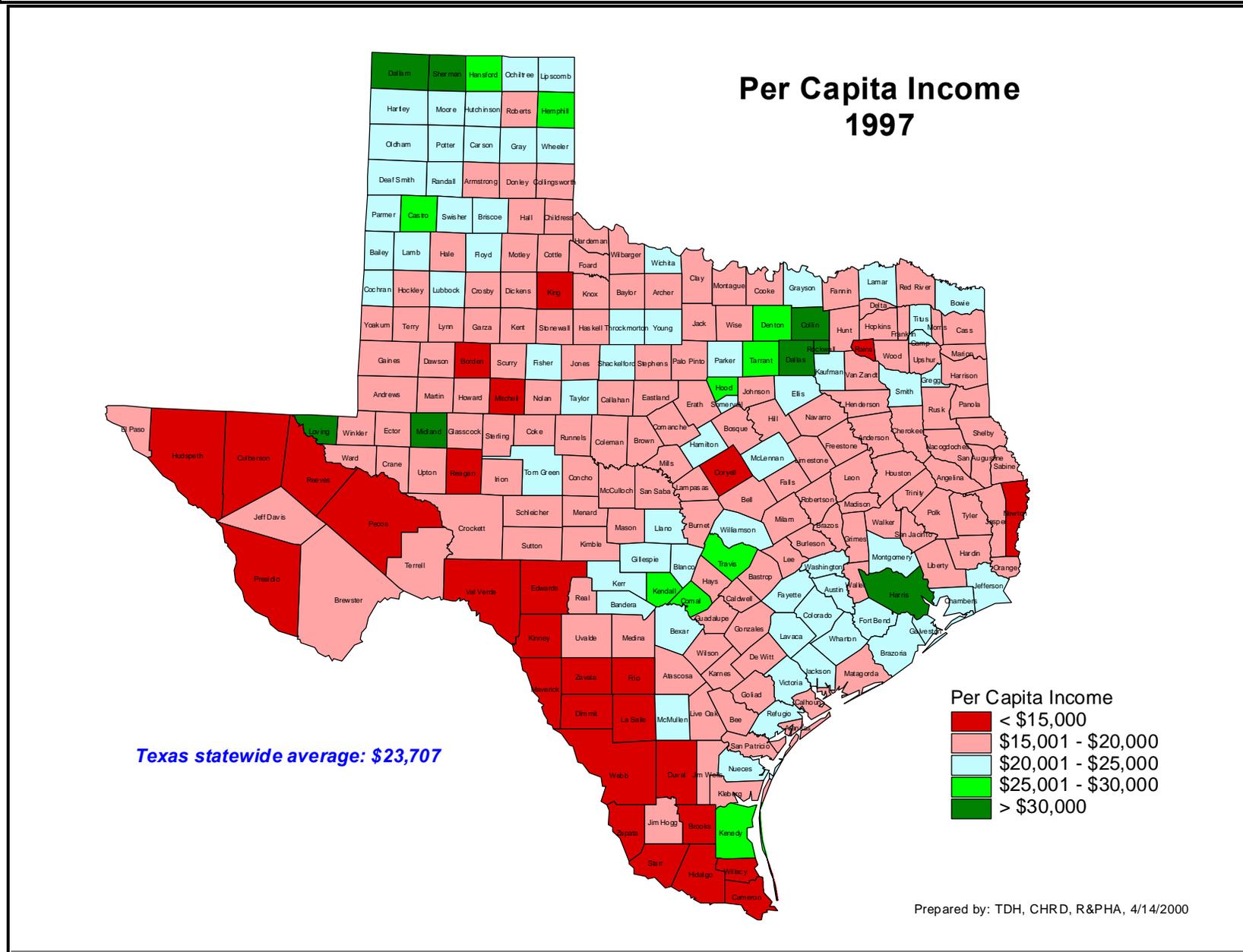


Figure 3

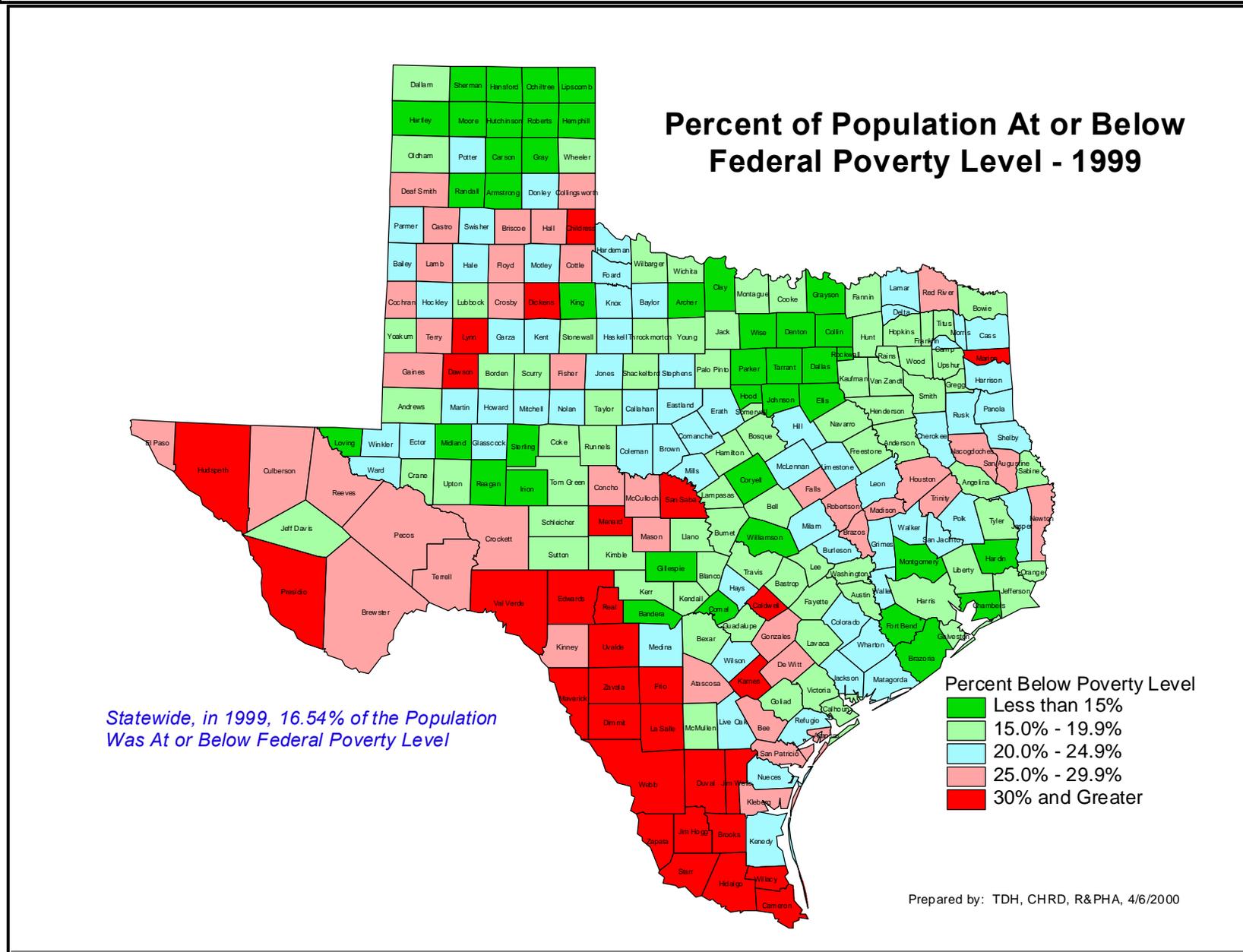


Figure 4

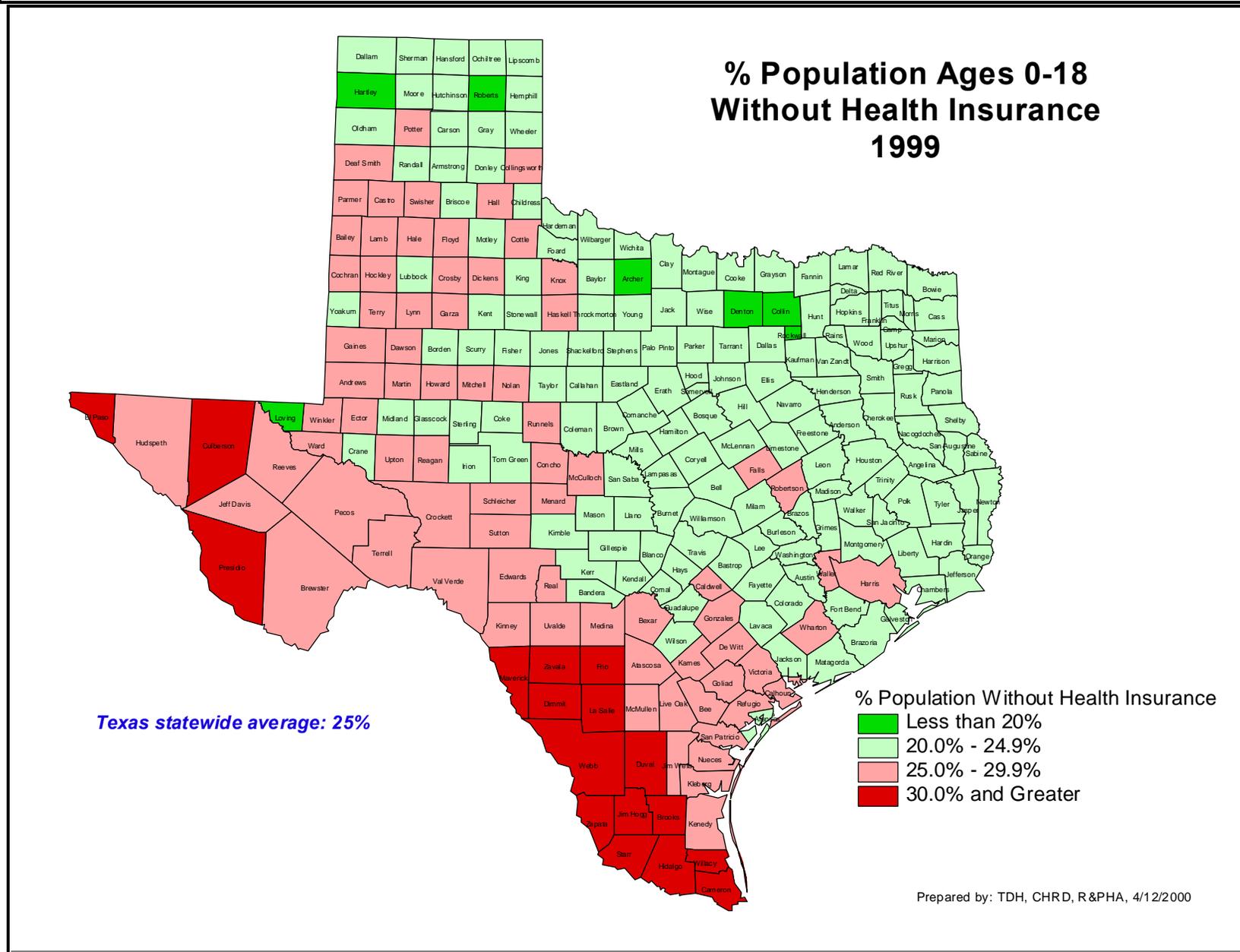


Figure 5

Additional Financial Barriers to Care for Children and Particularly CSHCN.

Issues within Medicaid program include:

- C Loss of Medicaid eligibility as children grow older;
- C Loss of Medicaid eligibility due to income increases
- C Asset tests keep many families with low income out of Medicaid
- C Month-to-month loss of eligibility for families on the Medicaid Medically Needy program due to changes in income related to spend-down requirements;
- C Loss of SSI and Medicaid when income and assets change;
- C Work disincentives in Medicaid and Social Security for parents who could work if their children had insurance; and
- C Lack of access to regular Medicaid coverage for undocumented resident children.

Issues in private insurance include:

- C Pre-existing conditions clauses preventing coverage even when parents are employed;
- C Lifetime caps;
- C Narrow benefits packages that do not include many services/supplies needed;
- C High deductibles;
- C Insurance benefits are not portable from job to job--loss of coverage; and
- C Loss of health insurance benefits through death and divorce.

Ongoing Programs that are Affecting Favorably Access to Care

CSHCN Redevelopment SB 374 of the 76th Texas Legislature mandates the state Title V CSHCN program to implement major changes to its policy, eligibility requirements, and program service delivery. The program staff are working on changing the definition of CSHCN used for program eligibility from a limited definition based on medical diagnoses to a much broader functional definition of chronic illness and disability; designing a program to provide CSHCN with access to a health care benefits plan similar in scope to CHIP and offering additional family support services for eligible CSHCN.

Medicaid Managed Care: Significant progress has been made in the Medicaid program toward providing more Texans with more appropriate care in cost-efficient ways. As of March 2000, there were 594,041 unduplicated Texans enrolled in the eight Medicaid managed service areas (Travis, Bexar, Lubbock, Tarrant, Southeast Region, Harris, Dallas, and El Paso). This represents an increase of 17%, over the 418,059 recipients enrolled in managed care as of April, 1999. Initial results from the "FY 97 Texas Medicaid Managed Care" report show that access to care has improved, inappropriate utilization of emergency rooms is declining, enrollee satisfaction is higher than that under traditional Medicaid, provider satisfaction with the timeliness of reimbursement remains the same level as in the traditional Medicaid, and cost savings are being made. In addition, another report "The Impact of Medicaid Managed Care on the Public Health Sector" concludes that the implementation of Medicaid managed care has caused local health departments (LHDs) to re-assess their roles and the services they provide in their communities. In a competitive managed care system, LHDs that choose to continue as

Medicaid providers must meet the qualifications for managed care and must also attract and retain Medicaid clients to succeed. More information on Medicaid managed care was presented in the Overview of the State Section.

Texas Children's Health Insurance Plan. See "Title XXI: Children's Health Insurance Program (CHIP)" in the Overview of the State Section.

Welfare Reform. The effects of welfare reform are not yet well-documented. Since the U.S. Attorney General has excluded Title V from being designated as a federal means-tested program, Texas Title V policy has not changed. As long as they are Texas residents, most unqualified women and children aliens may still be eligible for Title V services. Also, SB 445 of the 76th Texas Legislature creates state funded CHIP for legal immigrant children not covered by Title XXI.

Availability of Care The Title V MCH program provides accessible medical, dental, educational, and social services for infants, children and adolescents and women and their families in the area of preventive well-child visits, perinatal care and maternity visits, and family planning. Infants and children age 0-21 years and women through 44 years of age up to 185% of FPL are eligible to receive Title V MCH services (see Appendix A -- profiles -- for array of services and eligibility requirements).

For children who have specific covered diagnoses and meet the financial, age, and residency requirements, the CSHCN program provides health and related services related to that covered diagnosis to children 0-21 years of age up to 200% of FPL. The CSHCN program does not yet provide comprehensive health care. On the other hand, the program provides comprehensive case management services which assist eligible recipients to gain access to appropriate medical, dental, social, educational, and other needed services. The Medicaid program provides a continuum of primary, secondary and tertiary level care. Furthermore, the Medicaid program provides services to indigent households based on income and assets tests, with some exceptions, and served more than 1.4 million children in FY 98. There are also several Medicaid waiver programs that benefit CSHCN and adults with special health care needs which do not recognize parental income for Medicaid eligibility. They provide specific arrays of home- and community-based services, as well as access to regular Medicaid program benefits to target populations on a less-than-statewide basis. The waiver programs include: a) the Medically Dependent Children's Program; b) the Community Living Assistance and Support Services program; and c) two Home-and Community-based Services programs.

In addition, the Community Oriented Public Health program provides regional direct service contracts for preventive and outpatient services for persons of all ages up to 150% of FPL who are not eligible for other programs providing the same services.

In spite of major improvements, there are still significant gaps and barriers due to the shortage of health professionals.

Primary Care Physician. In 1998, there were 29,170 direct-patient-physicians 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 507 physicians per year. Since the

state's population also has increased during this time, the supply of primary care physicians has remained at about 57 to 59 primary care physicians per 100,000 population from 1991 to 1998. Twenty-eight of the state's 254 counties had no primary care physicians as of September, 1998, and 21 counties had only one practitioner.

In 1998, the projected population for Texas was 19.6 million. Fifteen percent of this population was located in 196 non-metropolitan or rural counties and 85% was located in 58 metropolitan or urban counties. In comparison, 11% of practicing primary care physicians were located in rural areas of the state, and 89% 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.

Other Shortage Areas. In 2000, there were 64 counties in Texas with no hospitals. Counties with a hospital but reporting no obstetrical service numbered 53. There were 65 counties with no physician assistants; 39 counties without a dentist; 72 counties without nurse practitioners; 35 counties with no licensed social workers; and 206 counties with no nurse midwives.

The Title V CSHCN program relies on specialists as well as primary care physicians. In the area of pediatrics, there were 3,612 pediatricians in Texas in 2000, and 141 counties do not have a pediatrician. Statewide, there were a total of 111 pediatric cardiologists; 29 pediatric endocrinologists, 66 pediatric surgeons; and 73 pediatricians with a specialty in hematology/oncology. There are no county level data available on shortages in these pediatric subspecialty areas.

Many CSHCN also require occupational therapy, physical therapy, and nutritional services. Recent data indicates shortages in a number of areas:

- C There were 4,319 occupational therapists and 97 counties had no therapists.
- C There were 7,096 physical therapists and 69 counties had no physical therapists.
- C There were 2,933 registered dietitians and 110 counties had no dietitians.

Health Professional Shortage Areas. The combined diversity of Texas' demography and geography challenges all residents in adequate access to health services. For a number of years Texas has led the nation in the number of primary care physician shortage areas. In 2000, 118 or close to 47% of the 254 counties are recognized as having too few primary care physicians including family practitioners, general practitioners, pediatricians, internists or obstetrician/gynecologists. Figure 6 shows that the Federally Designated Primary Health Professional Shortage Areas in Texas. Shortages were found for the entire geographic area of 118 counties. More than 2.5 million 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 118 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 118 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 80% of Texas counties designated as rural, access to primary and preventive health care services for about 3.1 million rural residents remain at risk. One hundred and eight counties (55%) of the 196 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.

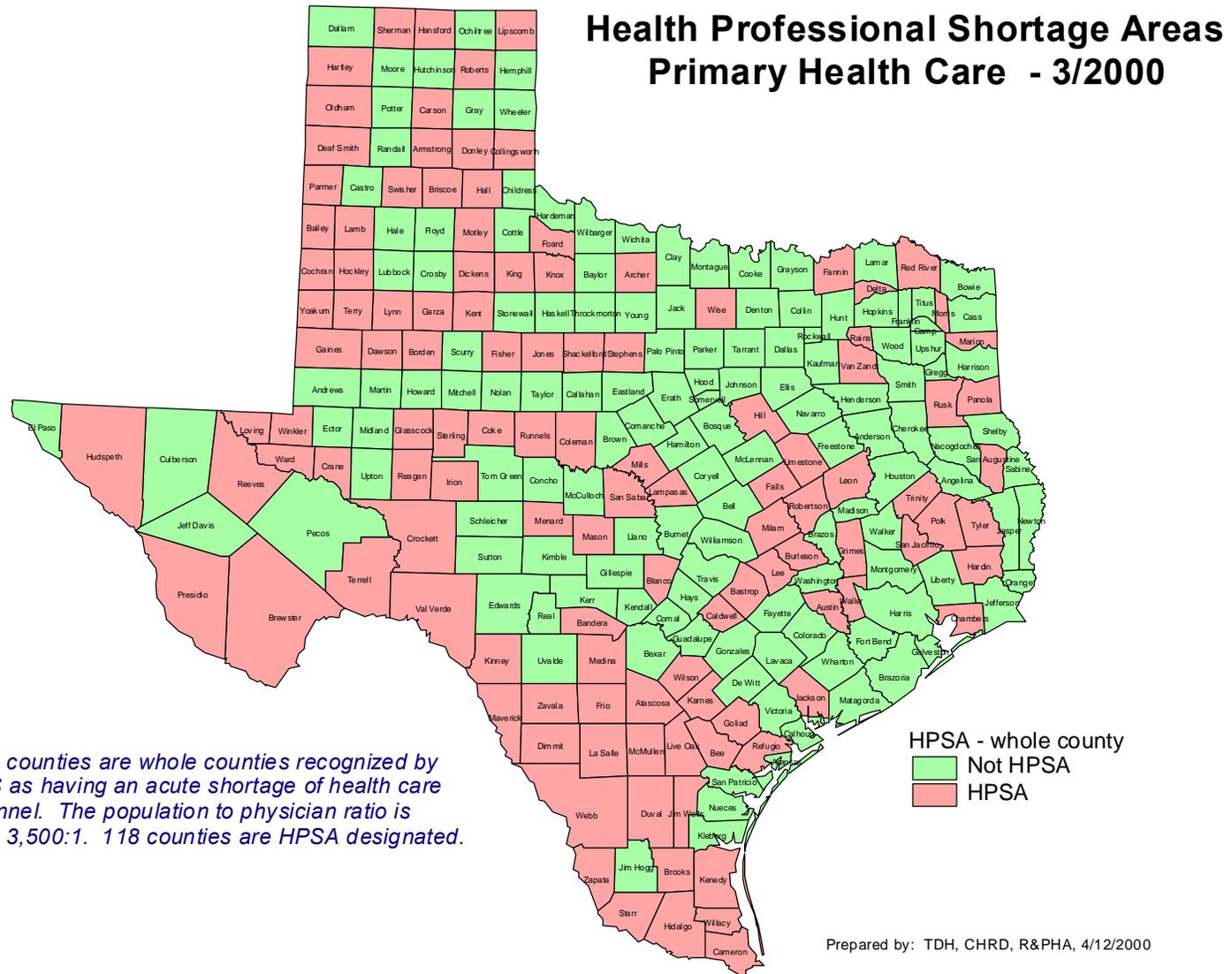


Figure 6

Ongoing Initiatives Designed to Reduce Health Care Professionals

To address rural health barriers to care, full implementation of the Rural Health Clinics (RHCs) program in Texas began in 1989 and allowed Texas to take advantage of enhanced reimbursement for rural health clinics under Medicaid and Medicare. A significant increase in the number of RHCs has occurred: 120 clinics in August, 1990 to 219 active clinics plus 81 pending applications in April, 1994. While not all of these clinics represent new services to rural areas, the expansion of RHCs has been an important factor in improving access to care in rural areas.

Title V set a priority to increase the number of women's health nurse practitioners by initiating a program to recruit and pay training for nurses in exchange for a commitment to work in public health for a two-year period. As of 1999, Title V recruited and paid for 183 nurses to receive nurse practitioner training.

In an effort to meet Texas' health care needs, the state's educational institutions are working to establish more branch or satellite campuses in areas that have been underserved by health care educational programs. The Texas Tech University Health Sciences Center through its Regional Academic Health Center in El Paso has instituted a nurse-midwifery training program. As a member of an El Paso coalition, they are providing community based health education and health care delivery through their primary care residency programs. The El Paso campus also reaches across the border into Juarez in a collaborative effort with Mexican agencies to develop a multi-site community and family-centered system for preventive, primary and continuing referral health care. The projects, sponsored by the W.K. Kellogg Foundation, provide models for efficiency delivery of health care in underserved areas as well as in developing countries.

The 75th legislative session authorized the University of Texas System to establish a Regional Academic Health Center in one of the 10 counties in the lower Rio Grande Valley. This decision was based on the shortage of primary care providers and a lack of preventive care in an area which is the largest in the state without an academic medical facility. In August, 1998, the University of Texas Board of Regents announced that the University of Texas Health Science Center in San Antonio will have primary responsibility for the lower Rio Grande Valley Regional Academic Health Center.

TDH and the Texas Higher Coordinating Board prepared a report on the Physician Workforce Strategy for Texas in 1995. As a result, in 1997, the Texas Medical Association reported that efforts are planned, among others: 1) to include more primary care faculty on admissions committees, 2) institute curricular changes such as introducing first year students to patient interviewing and physical examination skills, 3) establish of more community-based training sites, and 4) adopt problem-based learning programs. These efforts in Texas have resulted in an increase of Texas medical graduates selecting primary care training programs. In response to the 1995 Physician Workforce Strategy Report and the 1997 TMA report, the 75th Texas Legislature appropriated about \$25 millions to the Higher Education Coordinating Board to support the provision of medical and graduate medical education. Furthermore, the Texas Legislature HB 1511, which directs TDH to capture Graduate Medical Education (GME) dollars from its Medicaid reimbursement rates and distribute them to teaching institutions. In turn, GME was required to provide funds to medical schools for their affiliated primary care residency programs and independent residency programs. It is hoped that these significant efforts in curriculum reform and funding for GME will result in an increase in the number of

primary care physicians.

3.1.2.3 Enabling Services

3.1.2.4 Population-Based Services

The development and phase-in of population-based and infrastructure building services within the Title V service delivery was one of the major recommendations resulting from the 1995-96 Title V Futures Project. The latter's purpose was to "reinvent" Title V and related general revenue programs to adapt them to a changing health environment and to improve the health status of women and children. Furthermore, the need for population-based and infrastructure building services as means of addressing root causes, rather than being consumed by an endless assault on symptoms, still remains the main focus of the current TDH administration. This position is supported by the fact that human health is more than the mere absence of disease or injury. Rather, it depends upon a dynamic interaction of individual profiles in at least five distinct areas: behavioral patterns, social circumstances, physical environments, genetic structures, and health services received.

Below are descriptions of some of TDH population-based projects designed to address local needs and to guide community leadership in shaping future health and health-related decisions. Most of the projects are funded through a 3-year competitive request for proposals. The listed projects are supported by Title V funds, with the exception of the Innovation projects. Through close collaboration, staff from regional and central offices monitor and coordinate the projects by reviewing project quarterly progress reports, assess whether projects are meeting the objectives set in their initial work plans, and facilitate the provision of technical assistance.

MCH Population-Based Program. The Title V program has funded 33 projects through a competitive request for proposals process since 1996, totaling more than \$3 million a year. Projects are located in all TDH public health regions (PHRs). The number and type of services of projects in each PHR vary greatly based on local needs and resources. Of the 254 counties in Texas, 68 counties are covered by the MCH population-based projects. Overall goals of the projects are to address local health needs by building the local public health infrastructure and improving the health status of women, children and families. Contractors include local health departments, universities, county health departments, and private non-profit organizations.

The program is in an initial developmental stage, and projects are being run as pilots that focus on disease prevention, health promotion, and community outreach. TDH regional and central office staff provide consultation and facilitation to the 32 local contractors in implementing their projects. Examples of projects focus on developing and implementing public awareness and media campaigns about prenatal care, teen pregnancy, immunization, lead poisoning, child fatality, African-American congenital syphilis, and teen sexually transmitted diseases; developing and implementing clinical and educational materials on teen pregnancy, tobacco, alcohol and drug use, dental care, violence and weapons, parenting skills, motor vehicle injury, and sexual behavior; establishing outreach offices for prevention activities; developing and implementing eligibility screening tools for Medicaid, THSteps, and Title V programs; providing community/school education on HIV, breast feeding, helmet promotion, violence prevention, parenting skills, teen pregnancy, infant mortality, lead poisoning, hygiene, creating a healthy environment, communicable diseases, nutrition, healthy lifestyles, cancer awareness, diabetes,

and cardiovascular diseases.

In FY 2002, a new competitive RFA will be developed based on lessons learned and best practices.

Breastfeeding Initiative. The purpose of the Texas Breastfeeding Initiative is to increase breastfeeding rates in Texas. This initiative is being carried out by the Texas Breastfeeding Initiative Committee comprised of TDH breastfeeding experts, nutritionists, social marketing experts, specialists in maternal and child health, strategic planners, physicians, nurses, peer counselors, and communications experts. The mission is to create an environment in Texas that totally supports breastfeeding mothers in order to meet the Year 2004 targets of 75% at hospital discharge and 50% at 6 months postpartum.

Activities are designed to increase the awareness of the general public about breastfeeding, to develop breastfeeding promotion materials and resource packets, to identify barriers to breastfeeding to better target materials, to increase the breastfeeding management skills of health providers, expand the peer counselor program, to encourage hospitals to become baby friendly, to encourage businesses to become mother friendly, and to conduct media campaigns. Breastfeeding promotion and support materials and services are provided through WIC clinics, TDH clinics, hospitals, doctor's offices, private non-profit agencies, community health centers, home health nurses, and peer counselors. Public service announcements help garner support from the general public for the breastfeeding mother.

Male Involvement. Title V funds two Male Involvement projects in the Houston and Austin areas. Projects are community-based and involve the use of community coalitions which design and oversee each project. The primary goal of each project is to reduce the number of teen pregnancies within the target population.

Educational activities are provided to participants through contracts with agencies, such as local health departments, medical schools, private non-profit organizations, faith-based organizations, and community health centers. Currently, coalition-building activities are under way in the Rio Grande Valley and El Paso where two future male involvement projects are planned.

Abstinence Education Program. Thirty-one contracts have been awarded to a myriad of providers, such as non-profit or for-profit organizations, private or public organizations, governmental entities (city, county, and state), institutions of higher learning, independent school districts, faith-based organizations, and current TDH employees for the promotion of abstinence from sexual activity. Contracts are located in all PHRs with the exception of PHR 10.

The projects' activities include, but are not limited to, abstinence education classes, mentoring, counseling, and/or adult-supervision activities. The TDH Abstinence program encourages a comprehensive approach that targets pre-teens, teens, special populations such as young adult males or youth in juvenile detention center, and/or older adults such as parents, teachers or health care professionals.

Innovative Grants. TDH Innovation Grants were created in 1999 by the 76th Texas Legislature (HB 1676). The Legislature determined that a significant portion of funds received by the State of Texas from the recent tobacco legislation should be appropriated to certain permanent

funds. One of these permanent funds, called the Permanent Fund for Children and Public Health, was established for "certain public health purposes" and was appropriated \$100 million. The interest from the fund is available to TDH to accomplish the goals of the fund.

The intent of TDH Innovation Grants is to improve public health outcomes at the community level using innovations that can be replicated in many places in Texas. To the maximum extent possible, the grants are designed to bring about improvements in health status that are demonstrable or measurable. Approximately \$8,400,000 is expected to be available to fund projects in all three parts. In order to encourage creativity and innovation in proposals, TDH has left a large proportion of the grants funds available to uncategorized projects. A few categorized projects of particular interest to the agency are included as follows:

Part 1. Grants for Developing and Demonstrating Cost-effective Prevention and Intervention Strategies for improving Public Health Outcomes.

Part 2. Grants to local communities to address disparities in health minority populations.

Part 3. Grants to local communities for essential public health services. Grants submitted under this part will be allocated in such a way so that the total amount of funds available is equally divided between services for rural and urban areas of the state.

Nearly 300 applicants applied for almost \$60 million in grants in April, 2000. TDH was able to fund only a small proportion of applications. Grants were awarded to 43 applicants. Of these, 10 projects have a statewide scope and eight projects are located in PHRs 9, 10, 11, areas with predominantly Hispanic populations. The implementation of projects is expected to start in July, 2000 through FY 2001.

3.1.2.5 Infrastructure Building Services

Through the infrastructure building activities listed below, and those ongoing initiatives designed to increase the number of health care professionals (Section 3.1.2.2), TDH and Title V continue to integrate services, eligibility, and enrollment, and to standardize contract requirements. All of these efforts are geared toward two goals: improving access to health care services and providing continuity of care.

Mental Health. Texas Mental Health Mental Retardation (TxMHMR) has statutory responsibility for providing mental health services to Texans. However, recent legislation (SB 374- 76th Texas Legislature Session) for the CSHCN program, defined a child with special health care needs as "*...a person who has a behavioral or emotional condition that accompanies the person's physical or developmental condition. The term does not include a person who has a behavioral or emotional condition without having an accompanying physical or developmental condition.*" As a result, CSHCN redevelopment activities (as required by SB374 implementation due date 7/1/2001) include revising the health benefit plan to include limited behavioral health services. Title V CSHCN staff have been coordinating service delivery issues and referral arrangements with TxMHMR and the Texas Commission on Alcohol and Drug Abuse (TCADA).

In addition, the Texas Title V program, along with other state agencies, participated in the development of the Texas Children's Mental Health Plan (TCMHP) which is administered by

TxMHMR. The TCMHP ensures community-based systems of care through interagency collaboration and expansion and maximization of resources which are organized into coordinated networks to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families. Currently, through an RFP process, about 50 Community Management Teams receive funding to provide core and ongoing population-based services, systems development designed to establish interagency mechanisms and community plans, and early intervention services for children 0 through 5.

Title V also funds regional staff to participate in (or often to chair) Community Resources Coordination Groups (CRCGs) whose main objective is to procure health (in most cases, mental health) services for children who fall between the cracks. CRCGs often provide needed services through the TCMHP for children whose needs exceed available community resources.

Other significant changes that improve the delivery of mental health services include the newly-implemented Children's Health Insurance Program (CHIP). CHIP covers citizens and legal residents ages 0-18 up to 200% FPL and provides inpatient and outpatient mental health services, inpatient/residential and outpatient substance abuse treatment services as well as case management services for children with complex special health care needs.

Concerning Title V promising roles, Title V staff have been participating in the Texas Integrated Funding Initiative (TIFI) consortium activities including preparing a blueprint for the delivery of mental health services (including financing, administration, governance and delivery) as well as expanding the integrated funding initiative in six communities via an RFP process. The TIFI expansion provides an opportunity to develop community-based systems of care based on the recognition that children, youth and their families have multiple needs that cross traditional agency boundaries. The TIFI model may be applicable to children with other conditions.

Agencies in the consortium include TxMHMR, TCADA, Department of Protective and Regulatory Services, Texas Youth Commission, Texas Education Agency, and the Texas Juvenile Probation Commission. Family advocates (one for each agency represented) are equal partners in planning consortium activities. The target population for the TIFI initiative is children under age 18 who are receiving residential mental health services or who are at risk for residential placement to receive mental health services.

The TIFI values (family-centered, community based/local management and control) and model (pooling funds and coordinating across child-serving agencies to provide flexible individualized services) provide all agencies with an opportunity to learn how to involve communities more successfully in developing systems of care with integrated funding that improve outcomes. Education Service Centers are providing technical assistance and training resources to communities in developing local systems of care. The Federal Child and Adolescent Service System Program (CASSP) has provided strong leadership to the Health and Human Services Commission which is leading this interagency integrated funding project.

Perinatal Program. About than 50% of the pregnant women and newborns in Texas are covered by Medicaid. Texas bears significant costs for poor perinatal outcomes both at delivery and with the increased medical costs associated with newborns with long-term disabilities. Consequently, the 74th Texas Legislature in 1995 required TDH to adopt minimum standards and objectives to implement a voluntary perinatal health care system in order to

identify women who are most at-risk for poor pregnancy outcome and to prevent the occurrence of these outcomes by assuring access to a quality perinatal health care system. The rules were developed by Title V staff and approved by the Board of Health in 1999 for implementation. This program is a new activity to be organized with one full time employee in the Central Office, Bureau of Women's Health, but implemented and supported in all TDH public health regions by local staff.

Planning will occur at the regional and community level where stakeholders and practitioners will work together to identify ways to improve the health outcomes related to perinatal and infant health. Within this coordinated perinatal system, TDH Title V will play the role of a facilitator providing technical assistance to community-driven planning groups and disseminating related data specific to each region. Full implementation of the voluntary perinatal health care system is expected in 2003. The intent of this system is to help regions to minimize public health emergencies and to coordinate limited resources in each geographic area.

Service Delivery Integration (SDI). See "TDH Priority Initiatives Related to Maternal and Child Health" in the Overview of the State.

State System Development Initiative (SSDI): The Texas SSDI goals were designed to support the continued improvement of data capacity, data collection and data analysis. SSDI includes the following goals: 1. To improve the MCH/CSHCN surveillance capacity by the design, development and implementation of a web-based community assessment tool; 2. To assure Texas PRAMS has stable institutional support that ensures successful development and implementation; and 3. To improve the MCH/CSHCN capacity to report quality performance measures and health status measures.

Texas SSDI has joined with two other TDH initiatives funded by CDC to assure community based involvement in building data capacity at the local level. These initiatives are the Texas Health Alert Network and the Public Health National Performance Standards / Community Health Profile. The intent is to bring together local level public health user groups (i.e., local health departments, and so on) in the process in order to focus on data elements that are most useful to them for planning and funding public health programs. These data will be used to build the Texas Community Health Profile. Furthermore, integrated web-enabled information management systems in use by other states will be evaluated for recommendations to improve the accessibility of Texas data. The Health Alert Network will provide improved Internet access to many local health departments across the state. Data collection is an integral part of this initiative emphasizing a web-enabled reporting system to facilitate the accurate and timely reporting of health data into the TDH data system.

Another accomplishment of Texas SSDI during FY 2000 is the initiation of an exploratory process laying the foundation for the Pregnancy Risk Assessment Monitoring System (PRAMS) implementation. By nurturing institutional support and providing assurances for a successful development and implementation, SSDI has achieved a solid commitment and funding support from TDH administration. Through PRAMS, Texas will be able to gather specific data on maternal attitudes and experiences prior to, during, and immediately following pregnancy which, in turn, will help the Title V program to design better preventive interventions to improve maternal and infant health outcomes. In addition to promoting quality data collection and analysis, the MCH/CSHCN capacity to report quality performance measures and health status indicators has been advanced by institutionalizing data linkage methodologies

(MCHB Health Status Indicator #8). Title V now has the capacity to routinely link data between Medicaid (claims and eligibility) and birth certificate data, WIC data and other program data.

School Health Program. This program supports the development of comprehensive school health education and school-related health care services statewide through two major program areas: school-based health centers and the school health network. 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 under-served school age children and youth. The school health network consists of a school health specialist in each of the Texas Education Agency 20 regional education service centers to act as a liaison with school districts and to provide programming, information, curriculum, and other health related activities.

Furthermore, the 76th Texas Legislature permits TDH to fund school-based health centers (SBHCs) at \$250,000 per district for biennium with a preference for school districts in rural areas or those with low property wealth per student. The Title V School Health Program staff developed rules establishing standards for potential SBHCs which were posted on the Texas Register for public comments. The rules, along with the public comments, will be presented to the TDH Board of Health for final adoption in July, 2000.

Through a competitive request for proposals designed to reduce student absenteeism, to help them meet academic potential, and to stabilize the physical well-being of students, awards and negotiations with contractors will be finalized during Fall, 2000 and contract implementation is expected in January, 2001.

Family Health Services Information and Referral Line: Information on all programs within the Associateship is consolidated through the Family Health Services Information and Referral (I&R) Line. In addition, this line provides I&R on public/private providers of health and human services that complement the health services provided by TDH. The line is accessible by calling 1-800-422-2956 and includes the following programs:

- | | |
|--|------------------------------------|
| C Breast and Cervical Cancer Control | C Newborn Screening |
| C Children's Wellness | C Oral Health Services |
| C CSHCN | C Parenting classes |
| C Early Childhood Intervention (ECI) | C Prenatal Care |
| C Family Planning | C School Health |
| C Food Stamps | C TANF (formerly called AFDC) |
| C Immunizations | C Texas Genetics Network (TEXGENE) |
| C Medical Transportation | C Texas Health Steps |
| | |
| C Nutrition services for women and children (WIC) | |
| C Program for Amplification for Children of Texas (PACT) | |
| C Service providers for drug abuse (TCADA) | |
| C Service providers for mental illness (TXMHMR) | |
| C Service providers for the blind or visually handicapped (TCB) | |
| C Texas Health Steps (formerly EPSDT) | |
| C Texas Special Education hotline (includes information on children with disabilities) | |
| C Texas Rehabilitation Commission (job training for disabled persons) | |

3.2 Health Status Indicators

See Supporting Documents: Forms C1, C2, C3, D1, D2, and D3.

3.2.1 Priority Needs

Title V is concerned about the health status of all Texas residents. As shown in Section 3.2, one of the methods Title V uses to monitor the state's health is a set of indicators. These health status indicators, which provide measures of health or disease within Title V population, enable us to determine progress made toward achieving state and national goals established by Healthy People 2010 partnership. These indicators are also used to identify racial and ethnic disparities in health status which indicate unmet public health needs.

Based on the analysis in Section 3.2, indicators show improvement in many areas of the health of Texas' population. Others, however, show discouragingly little progress. As part of Texas' effort to improve health status and eliminate health disparities within Title V population, Title V staff include the following priority focus areas, highlighting priority needs for this reporting period. The priority focus areas are organized by the service levels of the pyramid.

Enabling Services

1. Many children with activity limitations or cognitive impairments need ongoing and long-term assistance, yet some do not require institutional care. In 1998, there were 1,288 Medicaid-eligible CSHCN who were institutionalized in state schools, ICF/MR, and nursing homes. Every CSHCN belongs in a family with a consistent caregiver who takes responsibility for the child's growth, development, and overall well-being. CSHCN still reside in nursing facilities and other congregate care settings. Families with CSHCN need family support services and care options so that CSHCN can remain in families within the community. Currently there is a lack of family support services and family support service providers. Also, there is no method for systematically identifying CSHCN who are at risk of institutionalization and ensuring that they and their families participate in permanency planning. In stakeholders' comments collected at various public hearings, forums, and focus-groups, as shown in Section 3.2, expanding opportunities for community-based services and expanding the availability of respite services for families of CSHCN were the most requested services. The availability of these family support services will address the need to reduce the number of CSHCN in nursing facilities and other congregate care settings.

Population-based Services

- 2 & 3. Social changes of the last 40 years have led to a dramatic shift in family, neighborhood and community patterns of interaction. Children are left to their own devices while parents are at the workplace, neighbors are absent, and elder citizens are in residential facilities. Recent evidence shows that, more than any other factor, health decisions among adolescents are influenced by the degree of connectedness they feel to family, school, and community. If we are to influence positively the health decisions that our children and youth make, we have to go beyond providing

information and teaching skills. We have to ensure that our youth experience a strong sense of connection and caring by the adults directly involved in their lives. We must realign our public health practice to consider and support the quality of life of our children and youth. In other words, the Texas Title V future initiative is to create a critical mass of asset-building energy around all children and adolescents, to the point that asset-building is a way of life in families, neighborhoods, and schools. Achieving this goal represents an opportunity to address the following priority needs: 1) to increase the number of adolescents who make healthy lifestyle choices for themselves and 2) to increase the number of children who thrive. The first priority need index includes A set of indicators, such as tobacco use, alcohol use, teen pregnancy, STDs (chlamydia), motor vehicle deaths, homicide, suicide, and high school dropout. The second priority need index involves the following indicators: immunizations, child abuse, unintentional injury, Medicaid checkups, childhood death 0 - 12 years. Both indexes combine healthy and unhealthy behaviors observed in children and adolescents in Texas. All of these indicators reflect negative behaviors except for the Medicaid checkups and immunizations. In 1998, data revealed that 67.4% of the total population aged 13-19 years chose healthy behaviors and 68.7% of the total population aged 0-12 years were thriving.

Below are selected indicators included in the above indexes that were used to describe the health status of the Title V population in the Needs Assessment Section . It is evident through these indicators that there is a need for social competencies to enhance the life skills children and adolescents need to be independent, capable, and competent.

- C The Texas rate of infant mortality has been lower than the national rates for all racial and ethnic groups since 1994. Yet despite a dramatic decrease in infant mortality for the total Texas population, the infant mortality for African Americans in 1998 was almost twice that of the overall infant mortality rate for the state.
- C Low birth weight birth is associated with adverse birth outcomes. From 1994 to 1998, there WAS no improvement in the percentage of LBW infants in Texas. The risk of giving birth to a LBW infant was much higher for African American mothers (12.6%) than for White mothers (6.8%) or Hispanic mothers (6.7%).
- C The proportion of live births born to mothers less than 18 years of age represents a measure of health risk among both adolescents and infants in a community. Racial and ethnic minorities in Texas are far more likely to have teen pregnancies than are Whites. Births among African American and Hispanic teens are two to three times higher than among White teens.
- C Prenatal care remains a priority public health issue. The proportion of women receiving prenatal care in the first trimester in 1998 rose to 79%, up from 76% in 1994. African American and Hispanic mothers were more likely to be in need of prenatal care in the first trimester of pregnancy than were White mothers.
- C Motor vehicle crashes are a leading source of injury-related deaths and are highly preventable. From 1994 to 1998, the motor vehicle crash death rate in Texas fluctuated considerably with the lowest rate (21.1) in 1995 to the highest rate (27.5) in 1996. In 1998, the Texas rate for motor vehicle crash deaths was 24.1 per

- 100,000, while the U.S. rate was 21.8 per 100,000 in 1997 (data for 1998 U.S. average are not available).
- C The suicide health status indicator is a direct measure of the mental health of the population and measures a health risk which is preventable. For adolescents aged 15-19, the Texas rate of suicide remained higher than the U.S. average between 1994 and 1997. In Texas, the suicide rate for Whites is 8.2, which is almost twice the rate for African Americans (4.7).
 - C The homicide health status indicator is a measure of intentional violence in a community. While the overall rates for homicide for all ages decreased between 1994 and 1998, they still remained higher than the U.S. averages. Yet despite a decrease in homicides in the total Texas population, the homicide rate for African Americans (24.4) in 1998 was more than twice that of the overall homicide rate for the state (9.1). Hispanics accounted for 12.8 homicides per 100,000 adolescents aged 13-19 years.
4. One of the TDH Women's Health Division priorities has been to decrease the prevalence of relationship violence through early detection and referral, which may prevent future injuries and decrease medical costs and lost days of work. Results of a five-year Title X Service Enhancement Project on family violence in Region VI (Texas, Arkansas, Oklahoma, Louisiana, and New Mexico)) indicate that Texas women receiving services from four TDH family planning contractors said they had experienced some form of sexual assault (27.3%) and physical abuse (38%). Division staff conducted a series of activities for Title X family providers to prevent abuse and identify victims. In FY 2000, in addition to expanding these activities to Title V and other health care providers, Division staff will develop a monitoring system to identify suspected victims of relationship abuse across Texas.
 5. In late-summer, 1992, TDH responded to an epidemic of cases of NTD-affected babies in the 14 counties along the Texas-Mexico border by securing a CDC grant and Title V funding. The goals were to identify NTD-affected pregnancies in residents of the area, to provide education and folic acid supplementation to high-risk women of childbearing age, and to conduct research to identify factors contributing to newborns with anencephaly and spina bifida. Between 1993 and 1997, 301 NTD-affected babies were born along the border, representing a rate of 13.4 per 10,000 live births. On average, more than 340 babies were born with neural tube defects in Texas every year, resulting in a rate of 8.6 per 10,000 live births in 1998. For FY 2000-05, efforts will continue to enroll high-risk women in folic acid intervention along the border and to provide statewide education on the benefits of folic acid supplementation to decrease occurrences of neural tube defects.

Infrastructure Building Services

6. Dental caries is perhaps the most prevalent disease in the state of Texas. The importance of optimal oral health for children cannot be overemphasized. Early diagnosis and prompt treatment of caries can stop tooth destruction and prevent tooth loss. Based on the 1997-98 TDH Statewide School Dental Survey of the School Lunch population, 3,407 third to seventh graders of 7,276 surveyed (47%) had caries. Data for 1999 showed little progress: Of the 7,001 children in the School Lunch

program, 3,829 (55%) had caries. Title V Oral Health Program staff are committed to reducing this percentage by first determining baseline children's dental health status, which helps not only in assessing the unmet needs but also in designing appropriate future activities to address specific dental needs.

7. Community water fluoridation has been the primary basis for the prevention of dental decay, which has been shown to lower the need for dental care. In 1999, 70% of the total Texas population had access to fluoridated water. Title V Oral Health Division staff will continue to maintain current water plant systems and to increase the proportion of the Texas population served by community water systems with optimally fluoridated water. This is a win-win proposition for the Title V program: community water fluoridation is equitable since the entire population benefits regardless of financial resources, and it reduces or eliminates disparities in preventing dental caries among different socioeconomic, racial and ethnic groups.
8. Overweight acquired during childhood or adolescence is associated with adverse medical and psycho-social consequences. Childhood obesity may persist into adulthood with increased risks of some chronic disease later in life. As a result, the rising prevalence of obesity and chronic disease will place more burdens on the health care system, including increased costs of medical care.

Following published data from the CDC's Third National Health and Nutrition Examination Survey (NHANES III), concern has been expressed that the prevalence of obesity in children and adolescents may be increasing in Texas. However, definitive data are lacking. NHANES III indicates that the prevalence of overweight from 1976-80 to 1988-94 INCREASED from 7.6% to 13.7% among children aged 6-11 years and from 5.7% to 11.5% in adolescents aged 12-17 years. In the 6 - 11 year old groups, obesity is highest in Hispanic boys and African American girls. In adolescents aged 12-17 years, obesity is highest in African American and Hispanic females aged 6-15. Among 363,480 total WIC clients aged 1-4 years old, 80,868 (21.1%) children were within the obesity risk code in 1999. Therefore, Title V leadership is committed to establishing a baseline to assess the extent of childhood obesity in Texas and, accordingly, to develop a plan of action to address this health risk.

FY 2001 List of MCH/CSHCN Priority Needs:

1. To reduce the number of CSHCN in nursing facilities and other congregate care settings.
2. To increase the number of children and adolescents who make healthy lifestyle choices for themselves.
3. To increase the number of children and adolescents who thrive.
4. To decrease the prevalence of relationship violence.
5. To decrease occurrences of neural tube defects.
6. To determine Texas baseline children's dental health status.

7. To increase the proportion of the Texas population served by community water systems with optimally fluoridated water.
8. To decrease child and adolescent obesity rates.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See Supporting Documents: Forms 2, 3, 4, & 5.

3.3.2 Other Requirements

Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort amount of \$40,208,728. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) lead prevention programs for children; 4) genetics services; 5) SIDS prevention activities; and 6) family planning and teen pregnancy prevention services.

Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These grants include: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) Centers for Disease Control and Prevention - Prevention of Neural Tube Defects; 4) MCHB - Texas Genetics Network; 5) MCHB - Newborn Screening Sickle Cell Program; 6) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 7) MCHB - Healthy Child Care North Texas; 8) Texas Cancer Council - regional school health specialists; 9) Centers for Disease Control and Prevention - Prevention of Secondary Disabilities; and Childhood Immunizations - Integrated Public Health Information System.

Budget Issues

The Texas Legislature allocates Federal Title V block grant funding and state general revenue funding to two strategies within the Texas Department of Health: 1) Maternal and Child Health (MCH) and 2) Chronically Ill and Disabled Children's Program (CIDC).

In the past, TDH has used unspent general revenue dollars in the CIDC strategy to provide additional MCH services. This was possible because CIDC had unexpended state dollars due to some policy changes beginning in the early- to mid-90s. The most significant of these changes were policies requiring potentially eligible CIDC clients to first apply for Medicaid, and implementation of OBRA 89, which resulted in Medicaid reimbursement for a variety of services that CIDC had been covering.

Beginning in FY98, Rider 4 of the 75th Texas Legislature prohibited TDH from transferring any unexpended general revenue dollars from the CIDC strategy to the MCH strategy unless permission was granted by the Board of Health (BOH) and the Legislature was notified. In

July, 1999, TDH received permission from the BOH to transfer unexpended general revenue dollars from the CIDC strategy to the MCH strategy for FY98 and FY99 in the amounts of \$7.9 million and \$7.0 million respectively. These state dollars would have lapsed if not transferred to MCH. Instead, Title V was able to use these dollars in lieu of spending federal carryforward dollars for FY98 and FY99.

Rider 4 of the 76th Texas Legislature does not permit any further transfers from CIDC to MCH, under any circumstances. In addition, legislation was enacted in the 76th Texas Legislative session that calls for expansion of the CIDC Program (CSHCN) and is it expected that this policy change will result in all the funds being expended in the CIDC (CSHCN) strategy. The result of both Rider 4 and the CSHCN legislation is that, beginning in FY2000, no additional dollars from the CIDC strategy will be available for the MCH strategy.

As TDH goes in to FY 2001, the Title V program has approximately \$23 million in federal carryforward. The MCH program is currently budgeting approximately \$10 million over appropriations. It is estimated that the Title V (MCH) program will spenddown most of the federal carryforward over the next 2 years. The Texas Title V program intends to align the MCH budget with the federal allocation and the state general revenue appropriation by FY2003. An exceptional item for additional state general revenue funding for the MCH strategy is being submitted in the TDH Legislative Appropriations Request for FY2002 and FY2003.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

3.4.1.1 Five Year Performance Objectives

See Supporting Documents: Form 11

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

**FIGURE 7
PERFORMANCE MEASURES SUMMARY SHEET**

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
5) Incidence of carious lesions among 3rd - 7th grade children.				X	X		
8) Percent of female clients suspected of being victims of relationship violence.			X				X
9) Rate (per 10,000 live births) of neural tube defects-affected babies.			X				X
10) Prevalence of childhood obesity				X			X
11) Percent population with fluoridated water				X	X		
12) Change in institutionalized CSHCN, as percent of previous year		X				X	
13) Percent of children and adolescents (aged 13-19) who choose healthy behaviors			X			X	
14) Percent of Infants and Children (aged 0-12) who thrive			X			X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

The following is a list of the proposed state performance measures accompanied by a brief discussion of each measure/category of service:

Enabling Services

Change in institutionalized CSHCN, as percent of previous year. Title V CSHCN program staff are firmly in support of community living options for children currently in institutions and congregate care facilities. In FY 2000, staff are participating in the Promoting Independence Board, charged by the Governor with the study and development of recommendations for active measures to ensure that people with disabilities residing in institutions who wish to move to the community may do so with adequate support services. Furthermore, starting in July, 2001, the CSHCN program will be revamped according to the 76th Texas Legislature SB 374, which requires it to provide eligible children and their families with access to an array of family support services. Permanency planning is one of the family support services which may be provided. Furthermore, the Title V CSHCN program's objective is to reduce the number of CSHCN in nursing facilities and other congregate care settings by 10% every year.

Population-based Services

Percent of children and adolescents (aged 13-19) who choose healthy behaviors & Percent of infants and children (aged 0-12) who thrive. Title V Child Wellness staff recognize that support and enhancement of essential developmental strength in adolescents, families and communities lead to improved health outcomes and well-being. Achieving this goal represents an opportunity for staff to develop indexes that include a combination of healthy and unhealthy behaviors observed in children and adolescent in Texas. The first index which

measures the percent of adolescents aged 13-19 years who choose healthy behaviors includes: tobacco use, alcohol use, teen pregnancy, STDs (chlamydia), motor vehicle deaths, homicide, suicide, high school dropout, and Medicaid checkups. The second index measuring the percent of children who thrive includes the following indicators: immunizations, child abuse, unintentional injury, Medicaid checkups, elevated blood level, and childhood death 0 - 12 years. In FY 2001, activity plans are proposed to promote and strengthen the degree of connectedness adolescents feel toward families, schools, and communities. Data estimates show that 68% of adolescents aged 13-19 years will choose healthy behaviors and 86% of children aged 0-12 will thrive by 2002. The achievement of these two performance measures will reduce the child death rate.

Percent of female clients suspected of being victims of relationship violence. Relationship violence often results in emergency room visits, physician office visits, hospitalizations, lost days of work, mental or emotional problems, or death. Studies show that more than half of the women murdered in the United States are killed by their male partners. It is estimated that, nationally, domestic violence leads to \$44 million in total annual medical costs and 175,000 lost days of work. Texas contributes to these alarming statistics, as indicated by the results of the five-year Title X Service Enhancement Project. Consequently, TDH Women's Health Division staff have conducted a series of activities for Title X family planning providers to prevent abuse and identify victims for referral. In FY 2001, similar infrastructure-building activities, such as the development of a tracking system for suspected victims of abuse and the provision of abuse prevention training, will be expanded to Title V and other interested health care providers. Data trend projections indicate that the rate of victims of relationship violence will be reduced to 3.5% in 2003. Reduction of relationship violence to women (including women before and during pregnancy) and their children would have an impact on outcome measures 1, 3, 4, 5, and 6, which relate to the mortality rate for children from the perinatal period through early childhood.

Rate (per 10,000 live births) of neural tube defects-affected babies. Research studies have shown that 50% to 70% of all cases of neural tube defects are preventable with a sufficient daily intake of the synthetic form of the vitamin folic acid, at a level of 400 micrograms per day. With this information in mind, and recognizing the impact of reducing NTD-affected pregnancies on statewide infant and child mortality, the Title V leadership is committed to continuing the NTD active surveillance along the border and to providing statewide education on the benefits of folic acid supplementation.

Infrastructure Building Services

Incidence of carious lesions among 3rd - 7th grade children and Percent population with fluoridated water . It is imperative for the Title V Oral Health Program to determine a baseline children's dental health status and to survey existing knowledge and behavior on the usage and benefits of oral health practices. The achievement of these infrastructure-building activities will allow dental program staff to set realistic targets and to develop targeted prevention activities in order to reduce the prevalence of dental caries. To the same end, Title V is allocating resources to increase the proportion of the total Texas population served by community fluoridated water from 70% in 1999 to 74% in 2003.

Prevalence of childhood obesity. Based on national data on childhood and adolescent obesity, action must be taken now to prevent a potential epidemic of childhood obesity in Texas. Priority attention by Texas Title V leadership is needed to determine a baseline for the prevalence of childhood obesity among a random statewide sample of 4th, 8th, and 11th grade

students and to collect data on menu planning procedures, preparation of foods, and nutrition-related policies from participating schools. Once the baseline is determined, the Title V Child Wellness staff, along with the Division of Nutrition Services staff, will assess the unmet needs and develop strategies for achieving the HP 2010 objective for adolescents. Childhood obesity is associated with numerous medical and psycho-social problems which can increase the mortality rate for children.

As mentioned above, each state performance measure relates directly or indirectly to at least one of the national outcome measures. Since all current outcomes deal with morbidity and mortality, it is important to develop a positive state outcome measure, such as the measurement of children's well-being, to reflect more accurately Texas Title V's commitment to community-based solutions and our emphasis on prevention. Staff from the Research and Public Health Assessment Division will define health indexes for Title V populations, collect, and analyze data to propose a state outcome measure which will be positively impacted by most national and state performance measures' activity plans.

3.4.2.3 Five Year Performance Objectives

See Supporting Document: Form 11

3.4.2.4 Review of State Performance Measures

Not Applicable.

3.4.3 Outcome Measures

See Supporting Document: Form 12

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a) (2) (A)]

4.1 Program Activities Related to Performance Measures

4.1.1 National Performance Measures

DIRECT HEALTH SERVICES

01 The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Type: Capacity

Population: CSHCN

Action Plan

1. Activity: Document the percentage of SSI beneficiaries under 16 who use case management/ family support services provided through the Title V CSHCN program.

Output Measure: Number of SSI beneficiaries utilizing CSHCN program services.

Monitoring: Review data on periodic basis.

Evaluation: Analyze data trends of SSI beneficiaries receiving services from the CSHCN program.

2. Activity: Disseminate referrals on SSI beneficiaries under 16 to regional social workers and CSHCN case management contractors for triage to determine type and level of interventions and make appropriate follow-ups.

Output Measure: Number of SSI beneficiaries under 16 referred.

Monitoring: Review data on periodic basis and follow progress on referrals.

Evaluation: Analyze data trends of referred SSI beneficiaries receiving services from the CSHCN program, assess the number and reasons of lost follow-ups (if any).

02 The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Type: Capacity

Population: CSHCN

Action Plan

1. Activity: Develop and implement new CSHCN program rules by July 1, 2001 per SB 374 of the 76th Texas Legislature. SB 374 requires the CSHCN program to 1)

change the definition of CSHCN used for program eligibility from a limited definition based on medical diagnosis to a much broader functional definition of chronic illness and disability; 2) eliminates the assets test from consideration for program eligibility; 3) requires the program to provide CSHCN with access to a health benefits plan similar in scope to CHIP; 4) continues to allow CSHCN to qualify for the program's health benefits plan through medical "spend-down" provisions (allowing CSHCN with family incomes >200% FPL and high medical expenses to document "medical indigence"); 5) requires the program to offer an expansive array of family support services (such as respite care, home modifications, assistive technology, etc.) for eligible CSHCN; and 6) allows the program to establish a waiting list in order to stay within budget.

Output Measure: New set of CSHCN program rules developed and approved by TDH Board of Health in the Spring, 2001.

Monitoring: Track progress on rules development, publication, and Texas Board of Health approval. Documentation of rules, policies, procedures, and implementation dates.

Evaluation: Assess the changes in the finalized rules due to the public input through the publication of the proposed rules.

ENABLING SERVICES

03 The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."

Type: Capacity

Population: CSHCN

Action Plan

1. Activity: Collaborate with Medicaid and CHIP in defining high quality of care parameters for CSHCN, including a definition of adequate medical home; develop a tool for data collection; and collect and analyze data to measure the quality of care for CSHCN.

Output Measure: Parameters defined; adequate medical homes defined; tool for data collection developed; report that includes results of the data collection and analysis.

Monitoring: Track progress of the different phases included in defining parameters, developing the data collection tool, and generating the report.

Evaluation: Send out the parameters and definition for review. Determine whether data collected were substantial and useful in assessing the quality of care for CSHCN.

POPULATION-BASED SERVICES

04 Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g. the sickle cell disease)(combined)].

Type: Risk Factor
Population: Women & Infants

Action Plan

1. Activity: Establish baseline data for the number of newborns born with at least one newborn screen by developing program software that accurately determines the total number of babies receiving at least one newborn screen by comparing BVS data with newborn screening data. The completion of this activity may take 5 years.

Output Measure: Software program that compares NBS data with BVS data.

Monitoring: Review periodic updates concerning development and implementation of the new software.

Evaluation: Analyze NBS data to determine accuracy of program by comparing hospital births with screens submitted by hospitals.

2. Activity: Educate mothers and health professionals about newborn screening benefits and state requirements by distributing brochures on newborn screening to health care providers; placing information regarding newborn screening on the newborn screening web-site; and making an email address available for any questions regarding newborn screening.

Output Measure: Type and number of materials distributed and web-site visits.

Monitoring: Ensure distribution of materials and document interactions with stakeholders through the web site.

Evaluation: Analyze NBS data to determine number of missed screens before and after dissemination of educational materials.

05 Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Type: Risk Factor
Population: Children

Action Plan

1. Activity: In collaboration with Texas A&M Extension Service and Take Time for Kids program, continue to develop and implement parent education train-the-trainer workshops for professionals, daycare staff, and community leaders to increase parents knowledge and skills about importance of well-child check-ups,

immunizations, and other children's health issues. Twelve workshops will be conducted statewide.

Output Measure: Number of workshops conducted per TDH public health region; number of participants per workshop.

Monitoring: Document the schedule of workshops and list of attendees

Evaluation: Review written post-evaluation of participants about workshops and make necessary adjustments to the curriculum. Assess the percent of children through age 2 who have completed immunizations.

2. Activity: The Take Time for Kids program will develop and distribute a parent education magazine for Title V contractors, parents of Medicaid children birth thru 4 years of age, and community organizations. The magazine will inform parents of medical check-ups and immunizations along with other age appropriate information on nutrition, child development, and basic care of the child.

Output Measure: The number of magazines in English and Spanish distributed.

Monitoring: Follow development and distribution of the magazine. Keep logs of those receiving entities receiving the magazine.

Evaluation: Assess the usefulness of Take Time for Kids magazine thru a survey of parent readers. Monitor the percent of children through age 2 who have completed immunizations.

3. Activity: Encourage Title V contractors and other providers of preventive child and adolescent services to provide preventive health care according to TDH Guidelines, American Academy of Pediatrics or Bright Futures guidelines. Current Title V policy requires 90 percent of children be current on well child check ups for age according to the periodicity schedule.

Output Measure: Number of well child/adolescent visits for Title V contractors.

Monitoring: Review quality assurance site visit reports documenting Title V contractor compliance.

Evaluation: Determine the number of contractors in compliance with the TDH well child and immunization requirements.

06 The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Type: Risk Factor

Population: Children

Action Plan

1. Activity: Provide family planning clinical and educational services to adolescents in regional offices of the Texas Department of Health or through TDH contractors.

Output Measure: The number of teenagers aged 15-17 enrolled in family planning services. Number of teenagers aged 15-17 served by county or region.

Monitoring: Review TDH contractor reports on the number and type of services

delivered on a quarterly basis.

Evaluation: Assess any change in the birthrate for teenagers aged 15-17 years by county or region.

2. Activity: Develop and distribute resource materials to raise public awareness of teen pregnancy.

Output Measure: Number and type of teen pregnancy prevention resource materials provided to clinics and other community-based organizations.

Monitoring: Ensure distribution of resource materials.

Evaluation: Assess the usefulness of teen pregnancy prevention materials.

- 07** Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Type: Risk Factor

Population: Children

Action Plan

1. Activity: Conduct statewide survey to measure the prevalence of dental sealants among third graders

Output Measure: Compile and analyze data

Monitoring: Track progress of survey design, data collection, and data compilation and analysis.

Evaluation: Standardize and calibrate collection methodology

2. Activity: Continue statewide promotion of sealant benefits by distributing educational materials for parents and teaching Tattletooth curriculum to children in selected Texas schools.

Output Measure: Number of children participating in Tattletooth curriculum; number of education materials distributed to parents.

Monitoring: Ensure timely distribution of parent educational materials; track TDH Regions and schools participating in Tattletooth curriculum.

Evaluation: Conduct a pre- and post-test survey on 3rd graders who received the Tattletooth curriculum.

- 08** The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Type: Risk Factor

Population: Children

Action Plan

1. Activity: Provide high-quality and attractive bicycle helmets and education concerning their use to children ages 5-14 in low-income families free of charge. Also provide incentives for their use.

Output Measure: Number of helmets distributed; number of local programs participating.

Monitoring: Track development and progress of distribution system.

Evaluation: Assess the effectiveness of the project by 1) conducting a post-survey study on the use and proper use of bicycle helmets and 2) reviewing crash reports involving bicycles.

2. Activity: Expand parenting education opportunities regarding car seat safety for children birth thru 4 years of age through the Take Time for Kids Parent Education Workshops and education of parent-employees in the workplace.

Output Measure: Number of workshops conducted by region; number of parents attending workshops by Region.

Monitoring: Track progress in conducting workshops, document schedule of presentations and attendance.

Evaluation: Written evaluation of the workshop in communities by participants; written evaluation of workplace education by participants and businesses.

3. Activity: Provide traffic-safety presentations to children ages 3-14.

Output Measure: Number of presentations conducted by region; number of children attending by region.

Monitoring: Track progress in reviewing the curriculum and educational materials and document schedule of presentations

Evaluation: Conduct a pre- and post testing of children to ascertain increase in knowledge.

4. Activity: Provide high-quality safety seats and education concerning their use to low-income families through a loaner program or free of charge [seats will be provided for children from ages birth to about age 6].

Output Measure: Number of seats distributed by region.

Monitoring: Track development and progress of distribution program.

Evaluation: Assess the effectiveness of the project by 1) conducting studies regarding safety seat use and 2) monitoring statewide crash data involving children.

- 09** Percentage of mothers who breast-feed their infants at hospital discharge.

Type: Risk Factor

Population: Women & Infants

Action Plan

1. Activity: Monitor breastfeeding rates of mothers using available data from Ross Labs Mother's Survey and the WIC program.

Output Measure: Percent of mothers breastfeeding at hospital discharge.

Monitoring: Review WIC data on a quarterly basis.

Evaluation: Analyze data to identify the characteristics of breastfeeding mothers and non-breastfeeding mothers at hospital discharge.

2. Activity: Improve community access to educational and support resources to promote breastfeeding by providing multiple venues such as a statewide hotline, maintaining the breastfeeding website, and funding community breastfeeding education initiatives.

Output Measure: Number of attendees at the Breastfeeding Summit. Number of calls to the lactation hotline. Number of volunteer breastfeeding peer counselors. Number of hits to the breastfeeding website. Number of requests to the Breastfeeding Speakers Bureau. Completion of licensure proposal for lactation specialists.

Monitoring: Review quarterly progress reports from hotline, website, and WIC.

Evaluation: Evaluate the use of the different types of resources developed and other specific types of requests for information and support.

3. Activity: Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps and Baby Friendly Hospital Initiative.

Output Measure: Number of letters sent to hospitals regarding accreditation. Number of new hospitals and birthing centers accredited.

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

Evaluation: Determine the number of hospitals and birthing centers which have not been accredited and follow-up to identify reasons.

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

Output Measure: Number of medical organizations endorsing Texas Breastfeeding Initiative activities. Number of physicians or health care professionals participating in training. Number of training participants recommending breastfeeding. Number of packets distributed to health care professionals. Number of surveys completed by health care professionals.

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

Evaluation: Determine if there was an increase in the percent of women breastfeeding at hospital discharge.

10 Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Type: Risk Factor
Population: Women & Infants

Action Plan

1. Activity: Conduct monitoring of newborn hearing screening programs to verify that they meet certification criteria through onsite visits and evaluation using the data and software system established to manage the program.

Output Measure: Number of programs monitored by region, percent of compliant programs versus non-compliant ones.

Monitoring: Document the schedule, location and results of each site visit.

Evaluation: Assess the level of compliance with certification criteria.

2. Activity: Provide NBHS training for hospital staff in all birthing facilities under Texas statute that required TDH to establish a system to screen all newborns before hospital discharge.

Output Measure: Number of trainings provided; number of hospital staff trained; number of participating hospitals.

Monitoring: Document schedule of workshops and attendance.

Evaluation: Review participant satisfaction survey results and reports from TDH trainer.

Infrastructure Building Services:

11 Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Type: Capacity
Population: CSHCN

Action Plan

1. Activity: Develop and implement rules and policies regarding the relationship of Title V CSHCN services to CHIP, Texas Healthy Kids, and Medicaid, with particular attention to referrals and the data exchange/ interface.

Output Measure: Rules and policies developed and implemented.

Monitoring: Track progress of rules and policy development.

Evaluation: Track the progress of development and implementation of rules and policies. Through data exchange with CHIP, Texas Healthy Kids, and Medicaid determine the numbers of CSHCN covered by these programs in addition to

those covered by the CSHCN program and other insurance.

2. Activity: Collaborate with the Children Health Insurance Program (CHIP) in outreach efforts to provide information on health care benefits options to CSHCN and their families.

Output Measure: Information specific to CSHCN and their families is provided in the CHIP outreach materials. Information about CHIP is provided by the CSHCN Program to CSHCN and their families.

Monitoring: Track progress toward development of materials and process and procedures for collaborative outreach efforts.

Evaluation: Type and amount of collaborative outreach efforts.

- 12** Percent of children without health insurance.

Type: Process

Population: Children

Action Plan

1. Activity: Monitor and report the percentage of children without health insurance.

Output Measure: Percent of children without health insurance.

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

Evaluation: Examine trends in child health insurance coverage and use data in program planning and interagency coordination efforts to increase the percentage of children with insurance coverage.

2. Activity: Confirm Title V program position through MOUs and procedures to integrate TDH Title V activities and data collection with CHIP and other state-funded insurance programs

Output Measure: MOUs and procedures developed, percentage of children without health insurance identified by Title V programs and referred to CHIP and other state-funded insurance programs.

Monitoring: Track progress in development and implementation of MOUs and procedures, follow up on each referral.

Evaluation: Assess the number of children without health insurance who are identified by Title V programs and referred to CHIP and other state-funded insurance programs who actually obtain insurance coverage.

- 13** Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Type: Process
Population: Children

Action Plan

1. Activity: Monitor and report the ratio of Medicaid child recipients who receive a Medicaid service compared to the population of all children who are potentially Medicaid eligible.

Output Measure: Number of Medicaid children birth through age 20 who received a Medicaid service, number of children birth through age 20 who are potentially Medicaid eligible.

Monitoring: Follow progress in updating report.

Evaluation: Analyze trends of the number of potentially Medicaid eligible receiving a Medicaid paid service.

- 14 The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Type: Process
Population: CSHCN

Action Plan

1. Activity: In addition to the 12 parent/family representatives on the Texas Department of Health's statewide CSHCN Advisory Committee, contract with a minimum of two parents of CSHCN to consult in developing and implementing a plan to enhance parent participation in program and policy activities.

Output measure: Number of contracts completed. Plan developed and implemented.

Monitoring: Track progress on every step of the contracting process until completion.

Evaluation: Review the progress and required criteria in selecting the best candidates.

2. Activity: Enhance TDH capacity to create family-centered program policies and services by developing and utilizing a "family-centered practice" checklist to assess the CSHCN program policies and practices and, as a local demonstration site for the National Center for Cultural Competence, develop and implement a plan to improve the cultural competency of service delivery systems for CSHCN.

Output Measure: Checklist developed and utilized. Cultural competency plan developed and implemented.

Monitoring: Review semi-annual reports, ensure distribution of cultural competency survey and follow progress in data collection and analysis.

Evaluation: Assess the extent to which the program policies and practices are family-centered and culturally competent based on the checklist and the plan activities.

3. Activity: Increase access to Title V hotline information and referral resources by providing access to this information via the CSHCN program website.

Output measure: Information posted on the website. Number of persons accessing the information via the website. Number of persons accessing the information via the hotline.

Monitoring: Review quarterly website and hotline reports.

Evaluation: Keep track of numbers of persons accessing the resource information and determine if there is any increase in access.

- 15** Percent of very low birth weight (VLBW) live births.

Type: Risk Factor

Population: Women & Infants

Action Plan

1. Activity: Assess the level and type of interventions needed for each geographic area and related sub-populations at risk, and consult with providers to implement strategies to reduce the occurrence of very low birth weight live births.

Output Measure: Number of strategies developed to prevent very low birth weight births. Number of consultations with Regional and local providers.

Monitoring: Document minutes from meetings with Regional and/or local providers located in geographic areas with high percentages of VLBW.

Evaluation: Analyze and profile geographic areas with a high incidence of very low birth weight births before and after the implementation of the strategies.

- 16** The rate (per 100,000) of suicide deaths among youths aged 15-19.

Type: Risk Factor

Population: Children

Action Plan

1. Activity: Collaborate with the Adolescent Health Program to provide Mental Health C.P.R. resources to local school districts through a loaner program at Regional Education Service Center.

Output Measure: Number of formal presentations on mental health CPR. Number of schools who have borrowed the curriculum and/or video.

Monitoring: Track schedule of presentations and utilization of these materials.
Evaluation: Analyze participant's evaluations forms and make necessary changes. Survey schools that utilized the video and curriculum.

2. Activity: Promote, facilitate, and disseminate the philosophy, methods and model strategies that promote the development of resiliency and other protective factors in youth.

Output Measure: Number of Regional Teams established to provide technical assistance about youth development to communities in their region. Number of communities who establish a Youth Development Initiative or a concerted effort to infuse youth development strategies into existing activities.

Monitoring: Track progress on development and dissemination of materials and methods to promote community-based youth development activities.

Evaluation: Survey public health regions about community efforts and activities regarding youth development.

- 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Type: Risk Factor
Population: Women & Infants

Action Plan

1. Activity: Provide training and consultation to enable public health regions to establish a regional perinatal care system to improve care for very low birth weight infants.

Output Measure: Number of consultations with regional staff. Number of regions completing an implementation plan for the perinatal care system.

Monitoring: Track developments related to implementation.

Evaluation: Assess the number and type of training and consultations provided to support regional staff activities and planning for implementation of the voluntary perinatal care system.

- 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Type: Risk Factor
Population: Children.

Action Plan

1. Activity: Assess the level and type of interventions needed for each geographic area and related sub-populations at risk and provide consultation to providers to implement strategies to increase the percent of infants born to women receiving

prenatal care beginning in the first trimester.

Output Measure: Number of strategies implemented. Number of consultations with provider staff.

Monitoring: Document minutes from meetings with Regional and/or local providers located in geographic areas with high percentages of women not receiving prenatal care beginning in the first trimester.

Evaluation: Analyze and profile geographic areas with a high occurrence of infants born to women receiving late or no prenatal care, before and after the implementation of the strategies.

4.1.2 State Performance Measures**Enabling Services**

12 Change in institutionalized CSHCN, as percent of previous year.

Type: Process

Population: CSHCN

Action Plan

1. Activity: Participate in the statewide Promoting Independence Board to collaborate with consumers, providers, and other agencies to support community living options for children in institutions and congregate care facilities.

Output Measure: Report and recommendations of the Promoting Independence Board.

Monitoring: Document minutes from meetings attended by CSHCN Program staff.

Evaluation: Analyze data trends of CSHCN in institutional settings.

2. Activity: Increase permanency planning and other family support services for CSHCN and their families to enable CSHCN to live with their families in the community.

Output Measure: Number of CSHCN and their families obtaining permanency planning and other family support services.

Monitoring: Track CSHCN Program utilization and expenditures for permanency planning and other family support services.

Evaluation: Determine if greater access to permanency planning and family support services impacts the number of CSHCN residing in institutional settings.

Population-based Services

13 Percent of children and adolescents (aged 13-19) who choose healthy behaviors.

Type: Process

Population: Children and Adolescents

Action Plan

1. Activity: Market and Distribute the magazine, "About Us", to the adolescent population enrolled in Medicaid as an effort to increase the number of adolescent health check-ups. There are (2) magazines, Younger Teen (age 11) and Older teen (age 15).

Output Measure: Number of medicaid eligible teens who had a health check-up.

Monitoring: Track number of magazines distributed to teens.

Evaluation: Review trends in the following health outcomes, 1) tobacco use by youth; 2) physical activity in youth; 3) injuries in youth; 4) teen pregnancy rates; and 5) STD rates.

2. Activity: Provide training on youth risk reduction and youth health promotion to healthcare and education professionals at regional Education Service Centers.

Output Measure: Number of workshops provided, number of participants and clock hours of training.

Monitoring: Track schedule of presentations.

Evaluation: Analyze workshop participants training evaluations. Review trends in the following health outcomes, 1) tobacco use by youth; 2) physical activity in youth; 3) injuries in youth; 4) teen pregnancy rates; and 5) STD rates.

3. Activity: Promote, facilitate, and disseminate the philosophy, methods and model strategies that promote the development of resiliency and other protective factors in youth. *Same as National Performance Measure #16 - suicide rate.*

Output Measure: Number of Regional Teams established to provide technical assistance about youth development to communities in their region. Number of communities who establish a Youth Development Initiative or a concerted effort to infuse youth development strategies into existing activities.

Monitoring: Track progress on development and dissemination of materials and methods to promote community-based youth development activities.

Evaluation: Survey public health regions about community efforts and activities regarding youth development.

4. Activity: Develop and distribute resource materials to raise public awareness of teen pregnancy. *Same as National Performance Measure #6 - teen pregnancy rate*

Output Measure: Number and type of teen pregnancy prevention resource materials provided to clinics and other community-based organizations.

Monitoring: Ensure distribution of resource materials.

Evaluation: Assess the usefulness of teen pregnancy prevention materials.

5. Activity: Provide funding to community-based initiatives to promote abstinence from sexual activity through strategies that include abstinence education, mentoring, counseling and/or adult-supervised activities.

Output Measure: Number of communities that have an abstinence education program funded by TDH and the service delivery area they serve.

Monitoring: Review abstinence contractor reports on the number and type of services delivered on a quarterly basis.

Evaluation: Determine the types of activities performed in each community and compare the number of activities to the decrease of teen pregnancy and STD rates.

6. Activity: Provide high-quality and attractive bicycle helmets and education concerning

their use to children ages 5-14 in low-income families free of charge. Also provide incentives for their use.

Output Measure: Number of helmets distributed; number of local programs participating.

Monitoring: Track development and progress of distribution system.

Evaluation: Assess the effectiveness of the project by 1) conducting a post-survey study on the use and proper use of bicycle helmets and 2) reviewing crash reports involving bicycles.

7. Activity: Provide traffic-safety presentations to children ages 3-14. *Same as National Performance Measure #8 - motor vehicle deaths*

Output Measure: Number of presentations conducted by region; number of children attending by region.

Monitoring: Track progress in reviewing the curriculum and educational materials and document schedule of presentations

Evaluation: Conduct a pre- and post testing of children to ascertain increase in knowledge.

8. Activity: Based on the review of the FY 2000 school based nutrition monitoring survey's results from regions 1, 4/ 5, and 8, TDH regional nutritionists will meet with school staff and develop and implement jointly an action plan addressing areas where the school can improve its food service, physical activity programs, and nutrition/health curricula. *Same of State Performance Measure #10 - childhood obesity*

Output Measure: Number of action plans developed.

Monitoring: Document meetings' minutes, follow up progress in developing action plans and seeking concurrence from the Public Health Nutrition Coordinator in the Central Office Division of Public Health Nutrition and Education.

Evaluation: Number of policy changes adopted by schools.

9. Activity: The Public Health Nutrition Coordinator in the Division of Public Health Nutrition and Education and TDH regional nutritionists collaborate with the University of Texas School of Public Health to implement a school-based monitoring survey to measure heights/weights and knowledge on the importance of nutrition and physical activity in a randomized state sample of 4th, 8th, and 11th grade students. *Same of State Performance Measure #10 - childhood obesity*

Output Measure: Number of participating schools by region; number of participating students by grade and region.

Monitoring: The regional nutritionists work with school administrators to collect and forward data to UT School of Public Health faculty for analysis.

Evaluation: Review the survey's results, which include obesity prevalence rates by schools and information on student's knowledge, attitude and behavior toward nutrition and physical activity.

10. **Activity:** The Public Health Nutrition Coordinator in the Division of Nutrition and Education and TDH regional nutritionists collaborate with the University of Texas School of Public Health to collect data on menu planning procedures, preparation of foods, and nutrition-related policies from participating schools' food service staff, teachers, and administrators. *Same of State Performance Measure #10 - childhood obesity*

Output Measure: Number of schools participating by region.

Monitoring: The regional nutritionists work with school administrators to collect and forward data to UT School of Public Health of Public Health faculty for analysis.

Evaluation: Review the survey's results, which include information on nutrition-related policies from participating schools' food service staff, teachers, and administrators.

11. **Activity:** Encourage Title V contractors and other providers of preventive child and adolescent services to provide preventive health care according to TDH Guidelines, American Academy of Pediatrics or Bright Futures guidelines. Current Title V policy requires 90 percent of children be current on well child check ups for age according to the periodicity schedule. *Same of National Performance Measure #5 - children immunized*

Output Measure: Number of well child/adolescent visits for Title V contractors.

Monitoring: Review quality assurance site visit reports documenting Title V contractor compliance.

Evaluation: Determine the number of contractors in compliance with the TDH well child and immunization requirements.

- 14** Percent of infants and children (aged 0-12) who will thrive.
Type: Process
Population: Children and Adolescents
-

Action Plan

1. **Activity:** In collaboration with Texas A&M Extension Service and Take Time for Kids program, continue to develop and implement parent education train-the-trainer workshops for professionals, daycare staff, and community leaders to increase parents knowledge and skills about importance of well-child check-ups, immunizations, and other children's health issues. Twelve workshops will be conducted statewide. *Same of National Performance Measure #5 - children immunized*

Output Measure: Number of workshops conducted per TDH public health region; number of participants per workshop.

Monitoring: Document the schedule of workshops and list of attendees

Evaluation: Review written post-evaluation of participants about workshops and make necessary adjustments to the curriculum. Assess the percent of children through age 2 who have completed immunizations.

2. Activity: The Take Time for Kids program will develop and distribute a parent education magazine for Title V contractors, parents of Medicaid children birth thru 4 years of age, and community organizations. The magazine will inform parents of medical check-ups and immunizations along with other age appropriate information on nutrition, child development, and basic care of the child. *Same of National Performance Measure #5 - children immunized*

Output Measure: The number of magazines in English and Spanish distributed.

Monitoring: Follow development and distribution of the magazine. Keep logs of those receiving entities receiving the magazine.

Evaluation: Assess the usefulness of Take Time for Kids magazine thru a survey of parent readers. Monitor the percent of children through age 2 who have completed immunizations.

3. Activity: Encourage Title V contractors and other providers of preventive child and adolescent services to provide preventive health care according to TDH Guidelines, American Academy of Pediatrics or Bright Futures guidelines. Current Title V policy requires 90 percent of children be current on well child check ups for age according to the periodicity schedule. *Same of National Performance Measure #5 - children immunized*

Output Measure: Number of well child/adolescent visits for Title V contractors.

Monitoring: Review quality assurance site visit reports documenting Title V contractor compliance.

Evaluation: Determine the number of contractors in compliance with the TDH well child and immunization requirements.

4. Activity: Provide high-quality and attractive bicycle helmets and education concerning their use to children ages 5-14 in low-income families free of charge. Also provide incentives for their use. *Same of National Performance Measure #8 - motor vehicle crashes*

Output Measure: Number of helmets distributed; number of local programs participating.

Monitoring: Track development and progress of distribution system.

Evaluation: Assess the effectiveness of the project by 1) conducting a post-survey study on the use and proper use of bicycle helmets and 2) reviewing crash reports involving bicycles.

5. Activity: Expand parenting education opportunities regarding car seat safety for children birth thru 4 years of age through the Take Time for Kids Parent Education Workshops and education of parent-employees in the workplace. *Same of National Performance Measure #8 - motor vehicle crashes*

Output Measure: Number of workshops conducted by region; number of parents attending workshops by Region.

Monitoring: Track progress in conducting workshops, document schedule of presentations and attendance.

Evaluation: Written evaluation of the workshop in communities by participants; written evaluation of workplace education by participants and businesses.

6. Activity: Provide traffic-safety presentations to children ages 3-14. *Same of National Performance Measure #8 - motor vehicle crashes*
- Output Measure: Number of presentations conducted by region; number of children attending by region.
Monitoring: Track progress in reviewing the curriculum and educational materials and document schedule of presentations
Evaluation: Conduct a pre- and post testing of children to ascertain increase in knowledge.
7. Activity: Provide high-quality safety seats and education concerning their use to low-income families through a loaner program or free of charge [seats will be provided for children from ages birth to about age 6]. *Same of National Performance Measure #8 - motor vehicle crashes*
- Output Measure: Number of seats distributed by region.
Monitoring: Track development and progress of distribution program.
Evaluation: Assess the effectiveness of the project by 1) conducting studies regarding safety seat use and 2) monitoring statewide crash data involving children.
8. Activity: Promote, facilitate, and disseminate the philosophy, methods and model strategies that promote the development of resiliency and other protective factors in youth. *Same as National Performance Measure #16 - suicide rate.*
- Output Measure: Number of Regional Teams established to provide technical assistance about youth development to communities in their region. Number of communities who establish a Youth Development Initiative or a concerted effort to infuse youth development strategies into existing activities.
Monitoring: Track progress on development and dissemination of materials and methods to promote community-based youth development activities.
Evaluation: Survey public health regions about community efforts and activities regarding youth development.
- 8** Percent of female clients suspected of being victims of relationship violence.
Type: Risk Factor
Population: Women and Adolescents
-

Action Plan

1. Activity: Develop and implement a pilot data collection system to track the number of suspected victims of abuse and the number and types of referrals made by health care providers who received training on abuse prevention.
- Output Measure: The number of data forms submitted; the number of referrals for services; the number of reported victims; the number of different types of referrals
Monitoring: Track development and implementation of data collection system.

Evaluation: Assess the usefulness of the information and data collected through the pilot data tracking system in determining the number of victims and identifying urgent and recurrent needs of victims of abuse.

2. Activity: Distribute a model policy for Title V and other interested health care providers upon request and seek feedback on the implementation of the model policy and procedures for victims of family violence/relationship abuse.

Output Measure: the number of manuals distributed; the number of reported victims; the number of requests for information from providers.

Monitoring: Track development and distribution of model policy.

Evaluation: Assess the usefulness of the policy manual by enclosing in the mailout a brief questionnaire to be returned to TDH.

3. Activity: Provide abuse prevention training to Title V providers, TDH regional offices, and other interested health care providers.

Output Measure: The number of presentations made; the number of participants from Title V providers, TDH regions, and other health care providers; the number of training conducted by TDH regional staff.

Monitoring: Document schedule of training sessions and lists of participants.

Evaluation: Review the evaluation forms completed by training participants.

- 9 The rate (per 10,000 live births) of neural tube defects – affected babies.

Type: Risk factor

Population: Women and Infants

Action Plan

1. Activity: As a result of the FY 2000 questionnaire which rates TDH folic acid education material usefulness, the MCH Nutrition Consultant will revise the TDH folic acid education materials.

Output Measure: Number of TDH folic acid materials revised.

Monitoring: Review and report quarterly progress.

Evaluation: The TDH regional nutritionists will field test revised folic acid education materials with family planning clients who receive services through TDH family planning contractors.

2. Activity: Public Health Nutrition and Education Division in collaboration with the Texas Folic Acid Council will distribute folic acid starter kits to TDH family planning contractors to be given to non-pregnant women of childbearing age during initial visit.

Output Measure: Number of folic acid starter kits distributed.

Monitoring: Track TDH contractors who received starter kits.

Evaluation: Assess use of multivitamins through statewide survey, e.g., BRFSS

and Texas Women's Health Survey.

3. Activity: The MCH Nutrition Consultant will collaborate with TDH WIC Program to develop a video on folic acid and NTDs.

Output Measure: Video produced in English and Spanish.

Monitoring: Track progress on production of videos.

Evaluation: Field test videos for acceptance.

Infrastructure Building Services

- 5 Incidence of carious lesions among 3rd to 7th grade children.

Type: Capacity

Population: Children

Action Plan

1. Activity: Conduct statewide survey of caries prevalence among 3rd to 7th grades children.

Output Measure: Number of school age children examined.

Monitoring: Track standardization and calibration for survey methodology; track progress on collection, compilation and analysis of data.

Evaluation: Review survey results and profile geographic areas and other indicators with high occurrence of dental caries.

- 10 The prevalence of childhood obesity.

Type: Risk Factor

Population: Children and Adolescents

Action Plan

1. Activity: Based on the review of the FY 2000 school based nutrition monitoring survey's results from regions 1, 4/ 5, and 8, TDH regional nutritionists will meet with school staff and develop and implement jointly an action plan addressing areas where the school can improve its food service, physical activity programs, and nutrition/health curricula.

Output Measure: Number of action plans developed.

Monitoring: Document meetings' minutes, follow up progress in developing action plans and seeking concurrence from the Public Health Nutrition Coordinator in the Central Office Division of Public Health Nutrition and Education.

Evaluation: Number of policy changes adopted by schools.

2. Activity: The Public Health Nutrition Coordinator in the Division of Public Health Nutrition

and Education and TDH regional nutritionists collaborate with the University of Texas School of Public Health to implement a school-based monitoring survey to measure heights/weights and knowledge on the importance of nutrition and physical activity in a randomized state sample of 4th, 8th, and 11th grade students.

Output Measure: Number of participating schools by region; number of participating students by grade and region.

Monitoring: The regional nutritionists work with school administrators to collect and forward data to UT School of Public Health faculty for analysis.

Evaluation: Review the survey's results, which include obesity prevalence rates by schools and information on student's knowledge, attitude and behavior toward nutrition and physical activity.

3. Activity: The Public Health Nutrition Coordinator in the Division of Nutrition and Education and TDH regional nutritionists collaborate with the University of Texas School of Public Health to collect data on menu planning procedures, preparation of foods, and nutrition-related policies from participating schools' food service staff, teachers, and administrators.

Output Measure: Number of schools participating by region.

Monitoring: The regional nutritionists work with school administrators to collect and forward data to UT School of Public Health of Public Health faculty for analysis.

Evaluation: Review the survey's results, which include information on nutrition-related policies from participating schools' food service staff, teachers, and administrators.

- 11 Percent population with fluoridated water.

Type: Capacity

Population: Title V population

Action Plan

1. Activity: Promote the health benefits of community water fluoridation and provide funding for new fluoridation systems and upgrades to existing fluoridation systems at the community level.

Output Measure: Number of newly fluoridated community systems and number of upgrades to existing fluoridation systems.

Monitoring: Track location of each new system or upgrade to system and number of individuals served by fluoridation system.

Evaluation: Measure the increase in systems and populations served.

Figure 8 shows a schematic approach that begins with the identification of priorities (through needs/resources assessment) and ends in improved outcome measures. Eight priorities are listed for which resource allocation is assigned and activity plans have been designed to

achieve the desired performance targets set for each performance measure.

Table 12 shows the distribution of both performance measure types by levels of service and MCH populations group. All MCH population groups are affected by at least one state performance measure. The resources and activity plans as measured by performance measures will impact a great number of Title V eligible clients. In FY 99, Title V programs served 122,552 pregnant women, 439,923 infants < 1 year of age, 438,294 children 1 to 22 years of age, and 68,241 children with special health care needs.

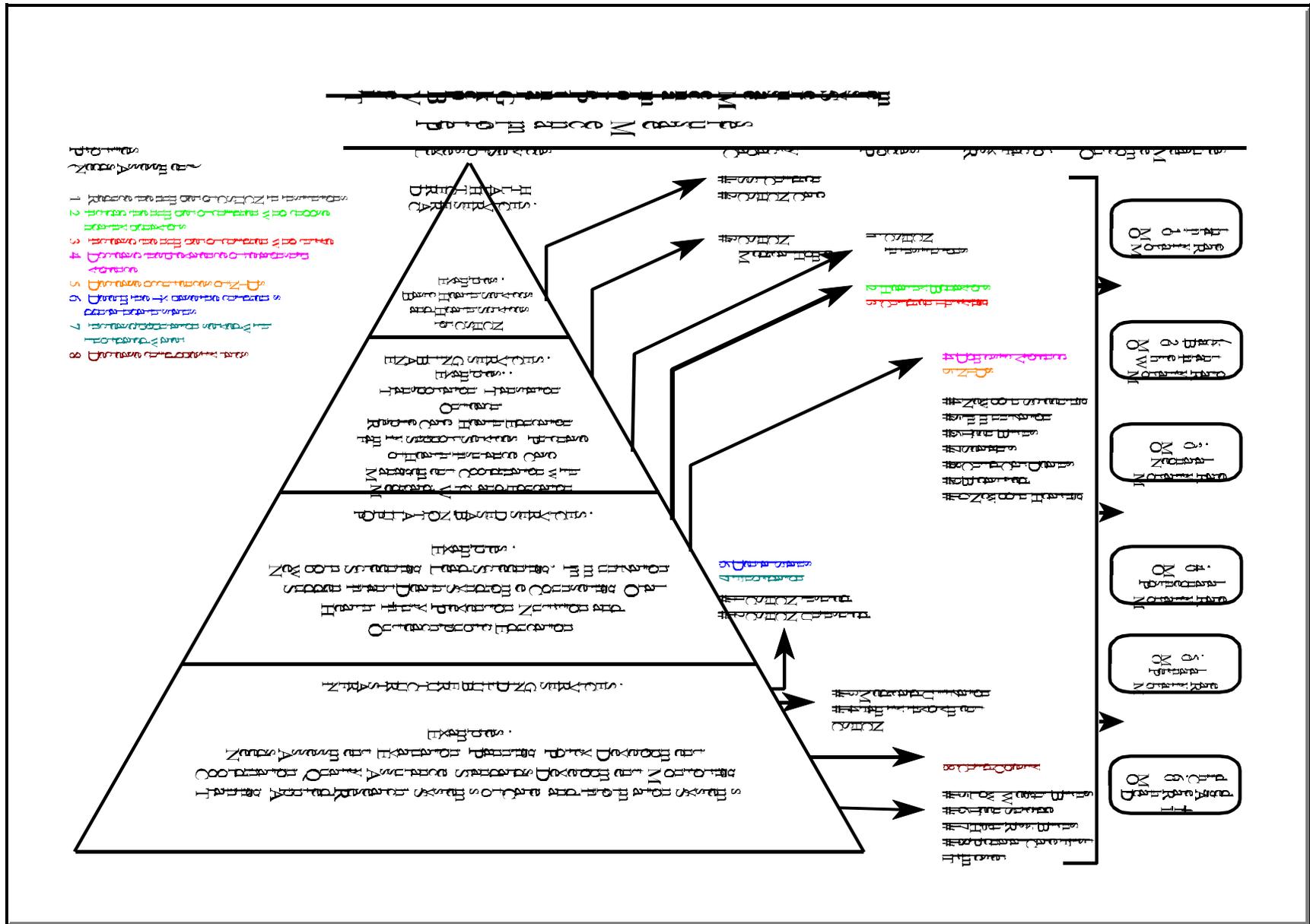


Figure 8

Table 12 Distribution of National and State Performance Measures

<ul style="list-style-type: none"> • National Measure • State Measure 		by Levels of Service and MCH Population Groups			
		MCH POPULATION GROUP			
LEVEL OF SERVICE	Women	Infants < 1 Year Old	Children 1 to 22 Years Old	Children with Special Health Care Needs	
Direct Medical & Dental Care Services <u>Examples:</u> basic health services, and health services for CSHCN				C SSI beneficiaries C specialty & sub-specialty services	
Enabling Services <u>Examples:</u> transportation, translation, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC, and education				C medical home C CSHCN in institutions	
Population-based Services <u>Examples:</u> newborn screening, lead screening, immunization, sudden infant death syndrome counseling, oral health, injury prevention, and outreach/public education.	C breastfeeding C neural tube defects C domestic violence	C genetic disorders C hearing impairment C neural tube defects	C immunization C teen pregnancy C protective sealants C motor vehicle-related deaths C domestic violence C healthy behaviors C children thriving	C neural tube defects	
Infrastructure Building Services <u>Examples:</u> needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, and applied research	C fluoridated water	C VLBW live births C VLBW infants delivered at Level III facilities C infants born to women receiving prenatal care C fluoridated water	C children without insurance C Medicaid eligible children C deaths by suicide C childhood obesity C students' dental health status C fluoridated water	C source of insurance C family participation fluoridated water	

4.2 Other Program Activities

Toll-Free Hotline

“BabyLove” is the statewide toll-free line that provides information on programs in the Associateship for Community Health and Resources Development. In addition, this line provides information and referral (I & R) on public/private providers of health and human services that complement the health services provided by TDH. The target populations for the toll-free line include: children from birth to 21, CSHCN and their families, women, parents, child caregivers, school health providers, family health care providers, community leaders, and outreach workers.

Associateship for Community Health and Resources Development programs listing the BabyLove number include:

- C Child Wellness Programs
- C Take Time For Kids Program
- C Texas Health Steps (formerly EPSDT)
- C Children With Special Health Care Needs (Chronically Ill and Disabled Children's Program)
- C Medically Dependent Children Program
- C Newborn Screening
- C Program for Amplification for Children of Texas (PACT)
- C Texas Genetics Network (TEXGENE)
- C School Health
- C Nutrition Services for Women, Infants and Children (WIC)
- C Family Planning
- C Prenatal Care
- C Oral Health Services

Related services on which information is generated include:

- C Medicaid
- C Medical Transportation
- C Food Stamps
- C Temporary Assistance for Needy Families (TANF)
- C Early Childhood Intervention
- C Immunizations
- C Parenting classes
- C Service providers for the blind and visually impaired (Texas Commission for the Blind)
- C Service providers for substance abuse (Texas Commission on Alcohol and Drug Abuse)
- C Service providers for mental illness and mental retardation services (Texas Department of Mental Health and Mental Retardation)
- C Texas Special Education hotline (includes information on children with disabilities, section 504 of the Rehabilitation Act)
- C Texas Rehabilitation Commission (job training for persons with disabilities)
- C Referral to licensed child-care facilities
- C Information on resources for children who are medically fragile

During FY99, the Associateship convened an Information and Referral Workgroup to examine to current and future needs of BabyLove. As a result, TDH updated the BabyLove database, purchased new I & R software, obtained I& R specialist training and certification for the BabyLove manager, and began a process of quality improvement around program data collection, monitoring and evaluation.

Coordination with Medicaid

The Texas Health Steps (formerly EPSDT) program is operated by TDH and is administered through a Division under the Bureau of Children's Health. Title V and Texas Health Steps program policies and activities are coordinated.

The Texas Department of Human Services (DHS) is responsible for Medicaid eligibility determination. TDH has an interagency contract with DHS to 1) perform oral information and referral on Texas Health Steps, Family Planning, and immunization services to newly eligible and recertified Medicaid clients; and 2) provide client eligibility data to TDH to facilitate program outreach and effective utilization of services. Under the contract, TDH is responsible for providing educational materials including videotapes for DHS waiting areas. Both agencies agree to share information and collaborate on issues related to coordination of the Texas Health Steps, Family Planning, Immunizations, Managed Care, and other Medicaid services. Each DHS and TDH review the MOU and publish any changes in the Texas Register.

TDH also has an MOU with the Texas Education Agency for the School Health and Related Services (SHARS) program. The SHARS program allows school districts to claim Medicaid reimbursement for ten health-related services (occupational therapy, physical therapy, speech/language therapy, medical services, school health and psychological services, assessments, audiology, counseling and special transportation). School districts certify the state share using existing state and local funds to receive the federal share. The MOU outlines individual agency and joint responsibility for program administration including communication with school districts, data collection, training, development of state rules, rate setting, and claims payment.

CSHCN program staff provide leadership in Medicaid medical policy development, in particular that for CSHCN, and the Medically Dependent Children Program (Medicaid Waiver) located in the CSHCN Division.

Coordination with Other Federal Programs

The Associateship for Community Health and Resources Development administers both the WIC and Family Planning (Titles V, X, XX, and XIX) programs. The Title V program coordinates regularly with these programs. TDH also serves as a member of the Texas Planning Council for Developmental Disabilities; the TDH representative to the Council is from the Bureau of Children's Health.

MOU for Coordinated Services to Children and Youth

TDH, DHS, the Texas Commission for the Blind and Visually Impaired, the Texas Department of Mental Health and Mental Retardation, the Texas Education Agency, the Texas Juvenile Probation Commission, the Texas Rehabilitation Commission, the Texas Youth Commission, the Department of Protective and Regulatory Services, the Texas Interagency Council on Early Childhood Intervention, and the Texas Commission on Alcohol and Drug Abuse maintain an MOU to coordinate services to children and youth who need services from more than one agency. The MOU provides support for the state Community Resource Coordination Group

(CRCG) Advisory Committee and 157 local CRCGs. CRCGs schedule staffings on individual children and develop strategies to address their multiple service needs through coordination of resources. TDH social worker at the regional level are represented on all local CRCGs, and TDH central office staff serve on the State Advisory Committee. The state CRCG Advisory Committee meets regularly and reviews its MOU annually.

Providers Who Refer Pregnant Women and Infants to Title XIX

In FY99, TDH contracted with providers across the state to provide MCH services including maternity, family planning and child health services. As part of the Title V eligibility determination process, Title V policy requires all providers to screen applicants for potential Medicaid eligibility. Potentially eligible Medicaid clients are referred to DHS. TDH has a software agreement with DHS to use the DHS Texas Eligibility Screening System (TESS) software to determine potential eligibility for services. All Title V providers are encouraged to use the TESS system or to collect equivalent information using other screening tools approved by TDH.

Coordination with CSHCN-Related Agencies and Family Support Programs

TDH coordinates regularly with the Texas Rehabilitation Commission Disability Determination Unit concerning children who are SSI-eligible.

TDH continues to involve consumers and advocates in program design and implementation and in statewide policy and systems development. TDH has a CSHCN Advisory Committee (CSHCNAC), established by the Board of Health (BOH), whose purpose is to advise the BOH on issues affecting CSHCN and their families. Three of the twelve members are parents of CSHCN. The CSHCNAC reviews and comments on policies, procedures and rules, and provides input to the MCH Block Grant.

In addition, families and advocates are active in state policy and systems development as partners with TDH and other health and human service agencies and organizations on the Regional Advisory Subcommittees for CSHCN in Medicaid Managed Care. Parents and interested consumer advocates have participated in monthly meetings to address policy and systems issues pertinent to CSHCN as Medicaid Managed Care is implemented in Texas.

Parents, as well as advocates, have been active participants in the redevelopment plan for the CSHCN program.

4.3 Public Input [Section 505 (a)(5)(F)]

In 2000, The Title V program, with the participation of other entities, solicited public input on the FY 2001 plan by conducting public hearings, forums, and focus-groups. To increase opportunities for participation from stakeholders, a public notice of each major event was also posted on the TDH Web Site with an e-mail address for input, and was published in the Texas Register. A sample of projects appears below. Each project description includes the purpose, population involved, and types of data collected, and references the coordination and collaboration between Title V programs and the public and private sector, state and local levels of government, and citizens involved in the development and implementation processes.

Public Hearings: The TDH Title V program co-sponsored a set of four public hearings during April, 2000, with the Department of Human Services, the Department of Protective and

Regulatory Services, and the Health and Human Services Commission. The goal of the hearings was to receive comments and suggestions on statewide programs directions and funding priorities for FY 2001-2002. State agencies receiving federal block grant funds are required to conduct a minimum of four public hearings every two years in preparation for the state legislative appropriations request. Comments and testimonies were collected at hearings in Houston, El Paso, Laredo, and Forth Worth. An average of 20 individuals gave testimonies at each site and about 120 letters were received through regular and electronic mail. Most comments concerned: 1) the limited access to dental care services for the elderly, and; 2) the limited availability of community-based services and family support services that foster independence and provide meaningful opportunities for the elderly and persons with disabilities to live in their home communities.

Regional Planning Forums: The forums are collaborations between the United Way of Texas, Regional Councils of Texas, Health and Human Services Commission and 12 Health and Human Services state agencies. Local United Ways and Councils of Government organized the forums at the community level. The purposes of the forums were: 1) to improve the delivery of state-funded health and human services in Texas, and; 2) to involve stakeholders, consumers and local community leaders in developing the next Health and Human Services Coordinated Strategic Plan. Twenty-one forums were held in selected geographic regions across the state. Most consisted of two parts: a morning session for public input and a facilitated afternoon discussion with invited participants to address some specific regional topics. The recommendations of the comments can be summarized as follows:

- C Improve community-based transportation services
- C Improve availability of information about services and continue development of the statewide information and referral system
- C Improve eligibility and enrollment processes for agency clients and customers
- C Improve coordination of children's special initiatives at the community level
- C Expand opportunities for community-based services, including expanding the availability of respite services
- C Develop and implement a long-range interagency project on how to prevent more effectively delinquency and conduct disorders in children an adolescents
- C Enhance the conditions that support good health and self-sufficiency in the South Texas colonias
- C Respond to the growing number of persons with diabetes by increasing public and policy-makers' awareness and making other appropriate policy changes.

Title V MCH Regional Stakeholder Meetings. A combination of factors led to the decision to initiate a series of meetings with Title V MCH contractors and regional staff, including the need to align the Title V program budget with annual appropriated funding levels, the need to define the role of public health in MCH direct, enabling, and population-based/infrastructure building services as the health care environment continues to change, and the need to consider internal and external factors (legislative mandates, ongoing program health initiatives) presenting opportunities or threats that could impact Title V MCH program decision-making. Eight meetings were held in each TDH public health region, followed up by a meeting in Austin with representatives from contractors and regional staff to stimulate further dialogue about the future role of Title V and to consider recommendations.

At each regional meeting, TDH regional staff and all MCH contractors attended the presentation and participated in the discussion. Summarized comments are organized into two categories:

1. Common themes.

- C Continue the provision of direct services
- C Document the value of population-based services
- C Develop and apply for a Medicaid family planning waiver
- C Simplify the eligibility process
- C Continue aggressive lobbying at the community level.

2. Unique Solutions.

- C Decentralize quality assurance activities to TDH public health regions
- C Include genetic services in family planning waiver

CSHCN Redevelopment Focus Groups. The Title V CSHCN program collaborated with the Health and Human Services Commissions and the Texas Council on Developmental Disabilities to convene three of the “Families Are Valued” project sites (in El Paso, Amarillo, and Austin), which are building THE capacity for permanency planning in their communities. About 40 to 60 participants (parents and providers) attended each meeting. Highlights of needs are identified as follows:

- C Make services available to middle-income families
- C Continue services to non-citizens
- C Increase the availability of respite services
- C Provide child care, including child care for children ages 12 -18 years
- C Improve THE existing information and referral system
- C Provide more training for parents and professionals

Comments were comprehensive and reflected diverse issues concerning Title V service delivery and its populations. Whenever possible, Title V staff translated comments and suggestions into performance measures and/or activities appearing in the proposed FY 2001 Annual Plan. For example, three new state performance measures are being proposed based on public input that relates to children and adolescents resiliency and thriving, and permanency planning for CSHCN. Other comments are in need of further clarification and/or analysis and are currently on hold.

The FY 2001 Application also will be made available to facilitate comment after its transmittal. It will be posted on the MCH homepage on the TDH web site. Copies will be sent to the Texas State Library, Governor’s Office and the Legislative Budget Board, and will be made available for TDH Advisory Committee members. A notice will be sent to all persons on the Title V interested persons mailing list to provide the opportunity to download or request a hard copy of the application.

4.4 Technical Assistance [Section 509 (a)(4)]

See Supporting Documents: Form 15.

V. SUPPORTING DOCUMENTS

5.1 Glossary

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4))*

Children - A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations.

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals. **Infrastructure Building Services** - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see "Types of Services")

Measures - (see "Performance Measures")

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the

target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of

uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801

et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about:
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a

condition of employment under the grant, the employee will-

- (1) Abide by the terms of the statement; and
- (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any

Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be

included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

No Material Included

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National “Core” Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets