

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: TX

APPLICATION YEAR: 2005

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

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

### **B. FACE SHEET**

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

### **C. ASSURANCES AND CERTIFICATIONS**

As per the Title V Block Grant Guidance dated May 31, 2003 the appropriate assurances and certifications are being maintained in the Title V Director's office and are available upon request. Please call Fouad Berrahou and/or Maria Vega at 512-458-7111 if you have questions or need to view the assurances and certifications.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

Since the FY 02 and FY 03 Title V budget realignment projects and with recent reductions in Title V state funds, Title V has been working with its stakeholders. Dialogue between the program and its stakeholders centers around the need to realign the program budget with appropriated funding levels and to define the role of public health in MCH direct, enabling, and population-based/infrastructure building services. Some of the collected information is used here, while the remainder will be addressed in the next 5-year needs assessment.

***//2005/ Public input on maternal and child health issues continues to be a component of Texas' Title V program. Title V programs use several mechanisms for soliciting public input. Different MCH program areas regularly convene or hold both formal and informal advisory committees, workgroups, public hearings, and other forums to address issues ranging from newborn hearing screening to children with special health care needs. Most programs use program websites and/or email to announce policy and rule changes and solicit feedback. For example, the School Health Program sends out a weekly email to those interested in adolescent and school health called "Friday Beat," covering a variety of issues and topics. Texas' Title V application will be made available to facilitate comment after transmittal and will be posted on the Title V website and copies sent to the Governor's Office and Texas' Legislative Budget board, and other stakeholders. Those on the Title V interested persons mailing list will receive notice of the new application and its availability electronically or in hard copy.//2005//***

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

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: provide and assure access to quality MCH services for mothers and children; provide and promote family-centered, community-based, coordinated systems of care for CSHCN and their families; and facilitate the development of community-based systems of care for the MCH and CSHCN populations.

Texas' Title V Program operates within the strategic plan framework articulated by Texas State Government, the Texas Health and Human Services Commission (HHSC) and the Texas Department of Health (TDH) and is an important component in achieving the Visions, Missions, Philosophies, and Benchmarks for Texas' priority goal for health and human services as outlined by the Governor's Office of Budget and Planning is to reduce dependence on public assistance through an efficient and effective system that promotes the health, responsibility, and self-sufficiency of individuals and families. The statewide benchmarks relevant to this goal are consistent with requirements of Title V and Title V national outcome and performance measures. The relevant statewide benchmarks include: Infant mortality rate; low birth weight rate; teen pregnancy rate; percent of births that are out-of-wedlock; incidence of vaccine-preventable disease; and number of surveillance activities and field investigations conducted for communicable disease injury or harmful exposure. The Vision, Mission and Philosophy of the TDH further support and strengthen the Texas Title V Program.

\*TDH Vision Statement: Texas is healthy people and healthy communities.

\*TDH Mission Statement: We partner with the people and communities of Texas to protect, promote and improve health. We accomplish our mission by providing and supporting the essential public health services of:

\*Surveillance, diagnosis and investigation of diseases, health problems and threats to the public's health.

\*Education, empowerment and mobilization of individuals and communities to prevent health problems and improve their health status.

\*Promotion of health policies and planning for individuals and community efforts to improve their health.

\*Regulation and enforcement of public health laws and policies necessary to control disease and protect the public's wellbeing.

\*Facilitating access to health services for individuals of greatest need.

\*Critically evaluating and refining our public health activities and workforce competence.

\*Supporting the health care safety net for children and adults with special health care needs, uninsured and underinsured people and families.

\*TDH Philosophy Statement. - We will accomplish our mission and goals by adhering to these values:

\*Integrity in all of our actions to build public trust.

\*Inclusiveness and diversity of perspectives to achieve the best solutions.

\*Partnerships with people, communities and organizations to build a successful public health system.

\*Accountability and responsibility to guide our use of public resources.

At the core of TDH's strategic plan are newly articulated priority needs created in partnership with internal and external stakeholders and consumers, the Board of Health and TDH executive managers. These priority needs have informed TDH of the need to strengthen the health status of individuals and to enhance public health systems in Texas. During the strategic planning cycle, TDH has set five priorities to achieve a healthy Texas that are consistent with Title V. Three priorities focus on improving the health of Texans:

Protect Texans against vaccine-preventable diseases by improving immunizations rates;

Focus on fitness by promoting healthy eating and regular physical activity; and

Eliminate disparities in health among population groups in Texas.

Two priorities focus on strengthening the public health system to better address health challenges:

Improve our ability to respond to disasters or disease outbreaks whether they are intentionally caused or naturally-occurring; and

Improve the efficiency and effectiveness of TDH business practices.

All five priorities are discussed in the Needs Assessment Section.

The success of the State's and the Title V Program's efforts to craft and implement a strategic direction depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women and children in the context of their communities. The following demographic, economic, and social trends provide an overview of some of these important characteristics for Texas.

/2004/ These priorities remain primary focuses of the department. They are a focus of much of the rest of this overview and will also be explored and addressed in the next five-year needs assessment. //2004//

***/2005/ While in FY 04, TDH's mission, vision and philosophy and priorities remained relatively constant, a significant transformation of health and human services (HHS) agencies, including TDH, is underway. This transformation, as mandated by House Bill 2292 of Texas' 78th Legislative Regular Session, is designed to create an integrated, effective and accessible HHS enterprise, under the direction of Texas' Health and Human Services Commission (HHSC). The transformed system will improve client access to services and the quality of those services, reduce administrative costs, strengthen accountability, and spend tax dollars more effectively. The transformed enterprise is designed to serve clients better, be more responsive to local and stakeholder input and needs, and emphasizes individual choice as well as striving to improve services, and manage costs through innovation and deployment of technology-based solutions***

***H.B. 2292 realigns similar functions of 12 of Texas' existing health and human services agencies (HHS) into 4 new departments under the oversight of the HHSC. Each HHS department will have a 9-member, governor-appointed council that will make recommendations regarding the department's rules and policies.***

***The transformed agencies include the:***

***\*Department of Family and Protective Services: formerly known as the Department of Protective and Regulatory Services;***

***\*Department of Assistive and Rehabilitative Services: formerly known as the Texas Rehabilitation Commission, the Commission for the Blind, the Commission for the Deaf and Hard of Hearing, and the Interagency Council on Early Childhood Intervention;***

***\*Department of Aging and Disability Services: consolidating the mental retardation and state school programs of the Dept. of Mental Health and Mental Retardation, community care and nursing home services programs of the Dept. of Human Services, and aging services programs of the former Texas Dept. of Aging; and the***

***\*Department of State Health Services (DSHS): includes the programs currently provided by the Texas Dept. of Health (TDH), including Title V Maternal and Child Health Programs, the Texas Commission on Alcohol and Drug Abuse, and the Health Care Information Council, plus mental-health community services and state hospital programs operated by the Dept. of Mental Health and Mental Retardation.***

***While some of the transformed agencies have already begun operations all will be in place by 9/1/04. A more detailed discussion on the transformed agency, DSHS now the TDH, is covered in the organizational structure section of this application. That discussion will further articulate the revised vision, mission and scope of DSHS.***

***Today, many Texans seeking health and human services face an array of organizations, office locations, and overlapping programs. This fragmentation can make the system difficult to navigate for clients. This transformation will mean significant improvements in services for clients as well as provide opportunity for more integrated, cooperative, and collaborative state agency focuses and initiatives. Over the course of the transformation, clients will see more organized and integrated delivery of services and will see improved quality of services available to those in need and make it easier for frontline workers to serve clients in a more holistic fashion. Tools will be developed to gauge client satisfaction, and HHS agencies will be responsive to the feedback received from clients, employees, providers, and others stakeholders.***

***With planning for and implementing consolidation and transformation, the DSHS vision and mission have been updated. DSHS vision reads: "Texans in need have access to effectively***

**delivered public health, mental health, and substance abuse services, and all Texans live and work in safe, healthy communities." DSHS mission is to promote optimal health for individuals and communities while providing effective health, mental health, and substance abuse services to qualified Texans in need.**

**In 6/03, HHSC released a draft of the HHS Systems Strategic Plan for public review and comment. The draft is available at [http://www.hhsc.state.tx.us/StrategicPlans/HHS05-09/HHS\\_StPlan\\_rv.html](http://www.hhsc.state.tx.us/StrategicPlans/HHS05-09/HHS_StPlan_rv.html). This draft proposal reflects the changes mandated by HB 2292 and looks at the future of HHS in Texas as a system, rather than as 12 separate, yet coordinated entities. The mission of HHS agencies, as articulated in this plan, is to develop and administer an accessible, effective, efficient health and human services delivery system that is beneficial and responsive to the people of Texas. The plan details 4 HHS system strategic goals that include preserving, enhancing and maintaining independence, promoting and protecting good health, achieving economic self-sufficiency, and ensuring safety and dignity.**

**Additional information on the transformation of Texas HHS system including an overview organizational chart and current individual transformed agency organizational charts are available at [http://www.hhsc.state.tx.us/Consolidation/Consl\\_home.html](http://www.hhsc.state.tx.us/Consolidation/Consl_home.html). The ongoing transformation of Texas' HHS agencies provides not only a framework for activities planned for FY 05, but for the future of maternal and child health in Texas.**

**TDH and Title V leadership have and will continue to be active stakeholders and participants in the planning and implementation of this transformation. The transformation bodes well for improved delivery of services to and improved health outcomes for the maternal, child, and children with special health care needs populations, in the coming years and provides a framework for FY 05 planned activities and programs including the upcoming Title V 5-year needs assessment. Real opportunities, and challenges, lie ahead in the delivery of health services to Texas. Texas Title V will be an active participant in meeting those challenges and maximizing the opportunities and this environment will serve as one of the cornerstones of the next Title V needs assessment.//2005//**

**/2004/TDH Public Health Region Structure:**

**Texas is organized into 11 public health regions. Staff in regions includes leadership, administrative structures and programmatic representation at the regional level who not only provides population based and enabling services but also in some cases (e.g., dental, immunizations, family planning and prenatal care) direct care services where a local health department is not present. The attached map will provide a reference point for further reading on efforts in the regions. //2004//**

**/2005/During FY 04, TDH regional structure remained the same. Regional staff carryout the work of public health promotion, education and in some cases, direct and enabling services provision at the local level. TDH regional staff provide guidance and technical assistance to local public health departments and Title V-funded contractors.**

**In efforts to improve maternal and child health services and to provide for more accountability for funds expended, Texas Title V programs worked with each PHR in FY 03 and FY 04 to develop, implement and monitor service level agreements (SLA) in the areas of population-based services, quality assurance, vision and hearing, contract monitoring and direct services. Each SLA amounts to a contract between the State Title V Office and each PHR and provides quantifiable time-specific goals, activities, and outcomes that each Title V-funded PHR agrees to complete during specified timelines. Title V staff is currently evaluating each region's reported activities and will offer additional direction, suggestions, and perhaps focus-target areas for FY 05 regional efforts. These focus-targeted areas could include evidenced-based population-based activities that each PHR will implement in the coming year. For example, based on research currently under review, the State Title V Office may ask each PHR to adopt specific population-based activities to address diverse issues such as low birth weight, teen pregnancy, immunizations, smoking cessation, etc., thus having a statewide impact on a priority MCH issue.**

**Transformation and consolidation of HHS agencies, will impact TDH's regional administrative structure and operations. An interagency workgroup is currently charged with designing the regional structure for administrative services across all health and human services agencies including DSHS. The ultimate goal of the workgroup is to identify opportunities for consolidation and optimization of administrative resources across all of the existing health and human service agencies. Considerations in this process include the role of local providers, local health department/districts, and other stakeholder entities; policy and contract management issues; statutory requirements for certain administrative service functions; and the relationship of regional hospitals and state facilities. This workgroup will develop an integrated structure that includes the number and location of regional headquarter and local offices, administrative functions/services to performed at regional offices, management structure, methods of operation, staffing plans, technology and telecommunication considerations, and administrative functions and services to be consolidated.**

**Title V program funds positions in each region, including regions that provide direct services. This transformation of regional operations will result in cost savings that include lower staffing costs, less equipment and overhead and reduced lease costs. Potential ramifications of the changes, for the Title V population and all populations served, include provision of HHS administrative services at consolidated locations, more timely service and improved customer access to those services. Service delivery and support will improve through the use of technology upgrades and increased skills training to employees. Providers will also benefit in that a more integrated system should result in increased efficiencies for providers who contract with 2 or more of the affected agencies. Each contractor will likely reduce the number of contracts entered into, points of contacts, and billings, while maintaining and even possibly increasing the amount of work performed. In addition, all 5 transformed agencies will begin to use the same geographical boundaries.**

**The transformation and changes to regional structure will be reported on in the FY 06 application. Regional transformation will not only impact current activities planned for FY 05 and beyond, but will serve as part of the environment in which the 5-year needs assessment is conducted. //2005//**

#### Demographic Trends.

/2004/ According to the State Data Center and Demographer, by the year 05 Texas' population is expected to grow from the current 20.8 million to 22.4 million and projected to be 35.0 million in 2040. The area with the highest level of population growth includes the Texas-Mexico border, Texas' central corridor from Dallas-Fort Worth through San Antonio and the Houston-Galveston area. Slower rates of growth are seen in the Panhandle, West Texas and Beaumont-Port Arthur areas. It is interesting to note, given Texas' vast geographical area, that by 2000 nonmetropolitan counties accounted for only 15.2% of Texas' total population (and accounted for only 8.8% of Texas' 1990s population increase), while metropolitan counties accounted for 84.8% of the population (and accounted for 91.2% of the population increase). Texas' population is also seeing increasing diversification and aging. As compared to all the other states in the nation, Texas has the third largest Anglo population (11,074,716), the second largest African-American population (2,421,653), the second largest Hispanic population (6,669,666) and fourth largest population of persons from other racial/ethnic groups (685,785). Texas population, like that of much of the rest of the nation, will continue to age and have nearly 1 in 5 persons who are 65 years of age or older by 2040 compared to fewer than 1 in 10 in 2000. The issues of aging and diversification of population are also clearly seen in the relationship between youth-status and non-Anglo status. Sixty percent of Texas' population aged 5 years and younger and 57% of the total population less than 18 years of age are non-Anglo. Texas is ranked 45 nationally in the number of person's aged 25 and older who completed high school and of the 1.8 million students in grades 7-12 in 1990 approximately only 1.0% dropped out of the public schools. Texas socioeconomic and service structures will continue to be challenged by a population that is larger, older, and increasingly diverse. Texas population is expected to experience the emergence of a new numerical majority. Population changes, coupled with Texas' size and complexity will challenge Texas' resources during this century.//2004//

***//2005/ There are no significant changes from the 04 update.//2005//***

#### Economic Factors.

*//2004/Continuing the trend from last year's update, Texas' unemployment rate remained stable, albeit higher than those reported just a few years ago. According to the Texas Statewide Labor Market Analysis; the seasonally adjusted unemployment rate in Texas for May 03 was 6.8%, the highest rate reported in Texas since May 1993. May 03 unemployment rates ranged from a low of 1.0% in Kenedy County (Region 11) to a high of 29.5% in Maverick County (Region 8). 15 of Texas' 254 counties (5.9%) reported double digit unemployment rates ranging from 10.1 to 29.5. East Texas counties, as well as the Texas-Mexico border, continued to have significant problems associated with unemployment. Most reports about Texas' economic picture indicate that the Texas jobless rate may have peaked and will likely see improvement in the near future.//2004//*

***//2005/When compared to reported FY03 figures the FY 04 Texas unemployment rate remained relatively stable. Texas' seasonally adjusted unemployment rate in 5/04 was 6.0%, a moderate decline from 5/03's rate of 6.8% and slightly higher than the 6/04 U.S. rate of 5.6%. As of 1/04, 76 Texas counties reported unemployment rates of 6.7% or higher and a total of 10 counties, primarily in the Texas/Mexico border counties, reported unemployment rates ranging from 12.5% to 23.5%. While unemployment remains a statewide concern that impacts the delivery of health care services to those in need, most reports about Texas' economic picture continue to report that continued improvement is anticipated in the next several years.//2005//***

#### Current Poverty Rates

*//2004/In FY 03, according to the HHSC published Demographic Profile of the Texas Population Living in Poverty, 14.9% of Texas' population lives at or below poverty, showing only a slight increase from the 14.7% reported in 2001. The issues of poverty continue to challenge state resources and impact overall health status. Of those living "in poverty," while Hispanics are proportionately the largest group in poverty (59.8%) they are only represent about 34% of the general population. Anglos and others represent 26.4 of those living in poverty and about 55% of the general population. African-Americans represent 13.8 of those living in poverty, but represent only 11.5% of Texas' general population. Those aged less than 18 years of age represent 41.5 of those living poverty, while those aged 65 plus represent 8.4% of those living "in poverty." Employment status, while classified as "in poverty," with 37.4% reporting that they are employed, 7.7% reporting unemployment, and 54.9% reporting that they are not in the labor force. Forty-nine percent have less than a high school education, with only 7.9% reporting a college or higher-level degree. Over 42% of those living "in poverty" have either both parents or the mother present in the home. Health care coverage remains a critical need for those living in poverty and according to the same reports 57% of those living "in poverty" in 2001 reported some health insurance coverage during 2000. //2004//*

***//2005/ FY04 poverty rates remained relatively static from those reported in last year's application. Looking further at poverty levels, the percentage of the population living below established poverty threshold is higher in Texas than in the nation (14.9% vs. 11.3%) and the proportion of white residents below the 100% FPL is much lower at 7.6%. Twenty-three percent of Texas' Hispanics and 24.3% of Texas' African Americans are below 100% FPL, twice that of the nation's poverty level and almost 1.5 times that of the state average. Poverty impacts health status and continues to impact Texas' maternal and child health populations. //2005//***

#### Texas Health Insurance Coverage Rates

*//2004/ Based on May 03 HHSC statistics, close to 5 million (4,959,829) Texans, or 23.5% of Texas' total population, report no health insurance. This represents a 2.1% increase over FY 2001 reported information. This slight increase may be attributed, in part, to Texas' sluggish economy, loss of overall job in the state and increase unemployment. The without health insurance population often turns to the public or not-for profit private sector for basic preventive and acute health care. Of these 5 million individuals, approximately 1.3 million (27%) are under age 18. Hispanics continue to be the largest segment of the uninsured population (59%), followed by Anglo/Other (29.8%), and African-Americans*

(11.2%). Educational attainment for this population is consistent with those reporting poverty status, with 41.3 of those without health insurance having less than a high-school education and approximately 8.9% reporting a college or higher-level degree. Of those without insurance, 65% report being employed. //2004//

***/2005/ Many national sources continue to report that Texas has the highest rate of uninsured persons in the U. S. One out every 10 people without insurance in the U.S. lives in Texas. In 2002, the last year for which full year data is available, 5.5 million Texans or 25.81% of Texas' total population were uninsured. HHSC estimates that 39.28% of Texas' Hispanics and 26.34% of Texas' African Americans are uninsured. Further, they estimate that 22.36% of all children under age 18, and 24.83% of all Texas women go without adequate or no health insurance coverage. 2003 figures are anticipated to be even higher. Addressing the issues relative to the uninsured and underinsured is a critical factor in achieving maternal and child health outcomes and will factor into the Texas FY 06 5-year needs assessment plan. Work is ongoing on several levels to address this issue.***

***In May 04, the Texas Department of Insurance (TDI) convened a forum on expanding health insurance coverage for Texas' uninsured. Participants were diverse and included government, industry and advocates. TDI currently has a HRSA funded State Planning Grant. This planning grant provides TDI with resources to collect data and conduct an in-depth analysis of the uninsured population, evaluate options for expanding coverage and reach consensus on the ideas and options to pursue for further consideration. TDI collected data via telephone surveys of non-poor uninsured, surveys of small employers, small employer health insurance fairs, 45 focus groups in 15 Texas cities/towns, an actuarial contract to develop data and analyze expansion options. Options developed as a result of this data collection and analysis and as presented during the May 04 forum include CHIP Buy-In for parents and children, Medicaid expansion to include lowest income parents, creation of a statewide purchasing alliance and low-wage worker insurance subsidies. With a supplemental grant TDI received in Oct. 03, they did follow-up surveys, analyzed plans, and evaluated options for college students and young adults. TDI has decided to focus initially on this last and largest group, college students and young adults, in identifying immediate future options. These efforts will likely have an impact on maternal and child health outcomes as this vulnerable age groups receives health care not only as they become parents but as they age. Next steps in TDI's process includes following up on the initial workgroup discussions from the conference and perhaps a follow-up conference in Fall 04. Initial workgroup discussion focused on brainstorming around some targeted areas that included creating health insurance access districts, expansion of coverage for the uninsured, working with hospital districts to fund the uninsured and others. TDH Title V office will continue to monitor TDI's efforts and address the issue during the next 5-year needs assessment.//2005//***

#### Health Professional Shortage Areas

//2004/Texas covers approximately 263,00 square miles and has 254 counties. In 03, 49.6% (or 126 of Texas' 254 counties) are designated as HPSA for primary care and 76 (or 29.9%) designated as HPSA for dental care and treatment. While the number of Medically Underserved Areas (MUA) for whole counties remained stable at 176, the number of partial county MUAs increased to 83 (in 48 counties). Texas currently has 67 local health departments that receive state funding and approximately 84 local health departments that do not receive state funding. Of Texas 254 counties, approximately 150 (or 59%) have no local public health presence but receive public health services by TDH regional offices.//2004//

***/2005/Any document addressing maternal and child health in Texas must include a discussion on health care providers as there is a direct correlation to access to maternal and child health services and the availability of providers providing those services. Texas' provider shortages continue and in part, frame the states ability to impact maternal and child health status. In FY 04, 51.6% or 131 of Texas' 254 counties are designated as HPSA for primary care and 79, or 31.1%, are designated as HPSA for dental care and treatment. The number of Medically***

**Underserved Areas (MUA) remained stable at 176, the number of partial county MUAs slightly increased to 88 (in 48 counties) in FY 04, not including 8 Federal Medically Underserved Populations (MUP) and 6 Exceptional MUPs.**

**A report entitled *Selected Health Professions -- 2002*, carefully details the Texas' provider picture. Texas ratios of health care professionals per 100,000 population are lower than the U.S. ratios, some counties have no providers and metropolitan county ratios are higher than nonmetropolitan county ratios. As Texas heads into the next Title V 5-year needs assessment cycle, the availability of all provider types must be further studied and addressed.//2005//**

/2004/These dynamic factors coupled with the department's existing priorities indicate an environment in which there are many opportunities to improve the health status of women and children. Texas is undertaking many activities that may improve the overall health status. //2004//

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.

/2004/The 78th Texas Legislature adjourned on June 2. A total of 5,592 bills were filed during the session. Ten of TDH's 14 initiatives passed. TDH tracked over 777 bills throughout the session and with as many as 126 having a definite impact on department operations and programs.//2004//

**//2005/TDH and Title V staff are working to implement or are monitoring implementation of the many mandates passed during the last legislative session. Many are covered in greater detail in the *Agency Capacity -- State Statutes* section of this application. Others that TDH is implementing or closely monitoring include an interagency workgroup on rural issues focused on interagency collaboration, drug manufacture rebate programs designed to maximize the purchase of pharmaceuticals, provider rate reductions in the Medicaid program, and medical treatment and parental consent. Each of these mandates, and others, affect the environment in which maternal and child health services are delivered and TDH will closely monitor and/or be involved in implementation of the mandates and assess their impact on program operations.//2005//**

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 I became effective July 1, 1998, as a Title XIX Medicaid expansion to extend eligibility to children ages 15 to 19 at or below 100% federal poverty level (FPL). With Phase I, the Texas Medicaid Program covers children from birth to 1 year of age up to 185% FPL, ages 1 through 5 up to 133% FPL, and ages 6 through 18 up to 100% FPL. CHIP Phase II is a state-designated program targeted to children ages 0 through 18 years of age at or below 200% FPL who are not otherwise eligible for Medicaid. Texas also covers legal immigrant children who are ineligible for CHIP under federal law because of their immigration status. Because these children are not eligible for the federal CHIP match, their coverage will be financed solely with state revenue. There are several features of CHIP worth noting: Eligibility is based on income, family size, insurance status, citizenship/immigrant status, and residency. There is no assets test. Eligibility is continuous for a 12-month period. Cost-sharing applies to all eligible families except for American Indians, including co-pays for families below 100% FPL; annual enrollment fees and co-pays for families between 100 and 150% FPL; monthly premiums and co-pays for families above 150 and at or below 200% FPL. Children must be uninsured for a minimum of 90 days (good cause exceptions will be considered). As of July 1, 02, TexCare has received almost 1 million applications since the beginning of TexCare in April 2000. CHIP enrollment for July, 02 is 519,630.

/2004/ CHIP continued to evolve during FY 03. As of June 03, Texas' CHIP enrollment is 512,986. This represents 59.2% of the 886,492 applications received. The renewal rate, accounting for normal attrition, stands at 72.6%.

The Texas Legislature in their recently completed 78th Session directed several significant changes in CHIP policy. While coverage continues for all currently covered populations (including state-funded

populations) and the eligibility levels are maintained at 200% of the FPL changes in program eligibility and coverage will have an impact on the health of children in Texas. These changes include: eliminating deductions to income so that eligibility is based on gross income; restriction of eligibility for families at or above 150% of FPL to those with assets within allowable levels; allowing for cost-sharing (i.e., co-pays and monthly premiums); changes in continuous eligibility from 12 to 6 months; establishment of a 90-day waiting period between eligibility determination and coverage; reduction of provider payment rates (5%); and establishment of a preferred drug list and prior authorization for those drugs not on that list.

Several specific exclusions were made from the benefit package and include dental, chiropractic and allergy services; vision care; and eye glasses. Several benefits including durable medical equipment, home health care, physical therapy, behavioral health services and audiology were also excluded, but may be restored if a cost-neutral method of funding can be found. Timelines for implementation are staggered, but many are expected to be in place by September 03.

***//2005/While significant changes designed, in part, to reduce costs have occurred in Texas' Medicaid and CHIP programs, HHSC reports that Medicaid and CHIP will actually cover more children during the FY 04-05 Biennium. Texas' Medicaid and CHIP environments frame the delivery of services for those in need in Texas and have significant bearing on maternal and child health populations. A separate update on each follows.***

***In FY 04, Texas' CHIP program, with appropriations totaling \$403.9 million, including \$143 million in state general revenue dollars, continued to evolve. Implementation of legislatively mandated program changes included a mandated waiting period of 3 months prior to start of coverage for new enrollees, re-enrollment every 6th months vs. annually, changes to what counts toward income, and a minimum monthly premium of \$15 for children from 101 to 150% of FPL. In discussions and meetings in which Title V staff has participated, Title V has learned that implementation of policy changes are causing the CHIP caseload to decline. Data on CHIP indicate that since the beginning of FY 04, CHIP caseload (available at <http://www.hhsc.state.tx.us/research/CHIP/ChipDataTables.html>) has dropped overall by approximately 119,000 children. As of May 04, 365,731 children are enrolled in Texas CHIP, down from approximately 500,000 children enrolled 2 years ago. The change from 12 to 6 months terms of coverage is reported as the largest single reason for the caseload drop. Markers in disenrollment and renewal rates further clarify the impact.***

***Texas CHIP reports that the 3 largest reported reasons for disenrollment are failure to complete the renewal process (38% of all disenrollment), mid-term status change resulting in enrollment in Medicaid (24% of all disenrollment), and finally families found ineligible after submitting renewal application (18% of all disenrollment).***

***Overall, renewal rates in FY 04 are slightly higher than in FY 03. For all children whose term of coverage ended in FY 04, 64% successfully renewed compared with 62% in FY 03, 25% chose not to renew as compared to 28% in FY 03 and 11% submitted renewals but were found ineligible as compared to 10% in FY 03. As reported by Texas CHIP, more frequently eligibility review has not discouraged families from submitting renewals though it does create a higher volume of children subject to renewal and eligibility verification.***

***Texas CHIP also reports that the effect of new eligibility requirements constitutes a small percentage of disenrollment in FY 04, for example in Nov. 03, 16,000 children enrolled in CHIP no longer qualified and were disenrolled, or about 12.3% of all disenrollment to date in FY 04. The new 3-month waiting period initially delayed new enrollment increases, but new enrollment is now on the incline. In FY 04, the average monthly caseload will be higher than legislative projections, upon which in part, the mandated changes were based. For example in FY 03, the actual average monthly caseload was 506,968, the FY 04 legislative projection was 380,603 while the FY 04 forecast is currently 406,760. In addition, a great number of children could lose CHIP coverage by 9/04 if families do not pay "cost-sharing" fees. HHSC created a grace period in 1/04 protecting families that have 3 unpaid premiums from being cut from CHIP. The grace period ends August 15 and HHSC has sent warnings to 70,000 families at least 1 month behind on their payments. Any changes in Texas CHIP coupled with changes in Medicaid continue to impact Texas maternal and child health populations. //2005//***

## Medicaid Managed Care

Texas currently provides services under the Medicaid managed care program in the 8 service areas, primarily centered in major metropolitan areas. These service delivery areas cover 43 county areas. As of July 02, a total of 767,581 clients were enrolled in Medicaid managed care. These clients are enrolled in either a health maintenance organization or the Primary Care Case Management (PCCM) model. As of July 02, 66% of clients were enrolled in HMOs and 34% were in the PCCM plan. The 76th Texas Legislature imposed a moratorium on expansion of Medicaid Managed Care pending a full evaluation and report to the 77th Texas Legislature in January 2001. That report was submitted and the moratorium was lifted following the 77th Texas Legislature. In response to cost-containment measures passed by the 77th Legislature, HHSC proposed the expansion of the PCCM program the remainder of Texas counties, where Medicaid managed care has not been implemented.

Another significant cost-containment measure passed by the 77th Legislature involves co-payments/cost-sharing in Medicaid. Texas recently submitted a proposal to CMS that is currently under review. It would impose a voluntary co-payment of \$3 for emergency services, 50 cents for generic medications, and \$2 for brand name medications in State Fiscal Year 03. In Fiscal Years 04-05, the co-pays would vary based on FPLs. This would impact both fee-for-service and Medicaid managed care recipients.

/2004/As of July 03, of Texas' 2,247,439 Medicaid recipients, 1,099,677 or 49% are enrolled in a Medicaid Managed Care model, as opposed to the 767,581 clients enrolled as of July 02. Again, this may be attributed to the impact of simplified eligibility coupled with an existing sluggish economy. As with CHIP/TexCare legislators made over 19 significant changes in Medicaid policy. While coverage continues for all children currently eligible and the continuous eligibility period remains at 6 months, significant changes include: establishment of enhanced asset verification; cost sharing; enhance compliance with personal responsibility agreements; and prior authorization requirements for high-cost medical services; and discontinuation of coverage for adult pregnant women over 158% of the FPL as well as for clients with incomes above 17% of the FPL (medically needy). Legislative changes also discontinue coverage for certain optional medical services for adults over age 21 including eyeglasses, hearing aids, podiatric, chiropractic and some psychological services. Legislation also directs the implementation of: disease management efforts; a preferred drug list and a four-brand name and 34-day brand supply limit for certain clients; an estate recovery program for Medicaid expenditures; decreased reimbursement rates (by 5%) for acute care providers as well as for non-acute providers (2.2% to 3.5%) such as nursing homes, community care providers and ICF-MR providers. While the changes are expected to save resources on the Medicaid funding side, the state may likely see a shift in the demand for services to other funding sources, such as the existing resource challenged Title V funding stream. Though a plan and rules written to implement the noted co-pays, pharmaceutical companies filed an injunction against the state to delay implementation of the noted co-pays. The state decided to repeal the rules and implementation of co-pays has not yet occurred.//2004//

Texas Kids Count 2000 indicates many families who need assistance and are entitled to public assistance program, were not receiving services. It also reported a decline in participation of many social services from 1995, prior to the implementation of the welfare reform law, to 1999, after its implementation. Social services showing a decline included Medicaid, Food Stamps, and TANF. While a direct causal relationship cannot be determined, factors related to eligibility and enrollment procedures, burdensome administrative requirements, and fear of problems with immigration status could have contributed to a decline, along with Texas' strong economy during that period. Texas Kids Count 2000 reports the following changes for the period 1995 to 1999: 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% from 1995 to 1999. 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% of the decline in TANF).

Between 1996 and 1999, the percent of poor children in Texas receiving Food Stamps dropped from 80% to 60%. Texas has seen a 47% decline in its TANF caseload between 1994 and 1998, a decline that is not fully explained by an improvement in the poverty rate. Census data shows that 18% of Texas children live in a family with one or more non-citizen parents. 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.

However, caseloads have been increasing since those figures were reported, and the economy has weakened. HHSC reports that Medicaid caseloads have increased since FY 2000 and are projected to continue to increase through FY 03. Most of the caseload increase is in the children's categories. The 02 Kids Count Data Book reports that Texas' median income for families with children (\$40,700) ranks last among the five largest states, and is more than 15% below this measure for the nation as a whole (\$47,300). It also shows that despite comparatively higher rates of work participation by Texas families, a higher proportion of the state's children live in working poor families (measured in the report at 150% of the federal poverty threshold and where at least one parent works at least 40 hours per week for at least 50 weeks per year). In Texas, 20% of children live in working poor families, compared to 15% nationwide. The proportion of Texas children in working poor families exceeds percentages in California (19%) New York (13%), and Florida (16%).

***/2005/ During FY 04, Texas' Medicaid program also continued to implement legislatively mandated changes. But as noted in the discussion on CHIP, more Texas residents are on both CHIP and Medicaid than previously reported. As of May 04, of Texas' 2,603,684 Medicaid recipients, 1,751,936 or approximately 67% are aged 0-18. HHSC reports that the Medicaid caseload is increasing overall, with decreases seen in specific risk groups as a result of policy changes. TANF Adult and Medically Needy Caseload have decreased while child risk groups have increased.***

***To further illustrate growth patterns based on a review of available information, from Aug. 03 to Feb. 04, Texas Medicaid reports a total caseload increase of 47,235. During the same time frame, Texas Medicaid saw an increase of 71,261 in child risk groups. This growth in children offsets decreases in other policy-impacted risk groups that include medically needy, TANF adult and pregnant women. While medically need recipients and TANF declined 12% and 24% respectively, pregnant women increased 1,943 from Aug. 03 to Feb. 04.***

***As of May 04, of Texas' 2,603,684 Medicaid eligible clients, 1,174,035 or 45% are enrolled in a Medicaid Managed Care model, a moderate increase to the 1,088,245 clients enrolled as of May 03. Texas' Medicaid managed care program, know as State of Texas Access Reform (STAR), uses 2 managed care models: a fully capitated HMO model and a Primary Care Case Management (PCCM) model. In both models, members have a medical home through a PCP. The bill guiding the HHS transformation, also directed HHSC to conduct a study to determine which managed care models are most effective for Texas' Medicaid program. Based upon the results of this study, several changes are underway in Texas STAR program. These changes, detailed at <http://www.hhsc.state.tx.us/medicaid/MMCEP.html>, include expanding the STAR HMO model into designated counties adjacent to existing service areas, implementing the model in 1 new service area (Corpus Christi area) and implementing the PCCM model in all remaining counties. Upon maturity of the changes, approximately 5 years out, estimated savings total \$72.7 million. All changes will be in place by May 05.***

***FY 05 caseload projections of 2,876,541 for all recipients, illustrate a continuing growth in Medicaid's caseloads. HHSC's formal evaluation of the changes and their impact is underway and will be reported on more fully in future applications. Texas Title V staff will closely monitor the impact of both increasing caseloads and implementation of changes on Title V population-in-need. //2005//***

***/2004/ The continued implementation of Medicaid simplification and the dynamics the state faces because of financial difficulties require that Texas leaders and policy makers be cognizant of how it compares nationally with other states in some key indicators. The 03 Kids Count Data Book reports***

that Texas are least likely (nationwide) to have health insurance, the most likely to live in poverty and highly likely of dropping out of high school and giving birth as teenagers, overall showing Texas lagging behind most other states in a range of indicators of child welfare. Texas' child poverty rank slipped from 36th (with 22% living below poverty) in 02 to 44th in 03. While the median family income of families with children increased to \$42,700, more than 1.03 million Texas children, about 21% of Texas' child population are estimate to be living in families with incomes below the FPL. Texas ranks 40th with 22% of its children lacking health insurance compared with 12% nationally. Texas statistics report that 23.5% of children do not have health insurance. Texas ranks 9th in the nation (and better than national averages) in infant mortality rates with a rate of 5.7 infant deaths per 1,000 live births. Teen pregnancy rates remain high for 15-17 year olds, with 42 births per 1,000 to rank Texas 49th in the nation. High school drop out rates (13% of teens aged 16-19) ranked 47th highest. In Texas, the percentage of poor people exceeds the national poverty rate, and Texans make up almost one-tenth of the whole nation's poor population. The very poorest communities in the nation, according to the US Census Bureau, are in Texas, specifically along the Texas-Mexico border. The state of women and children's health in Texas is dynamic and resource challenged; finding new and better ways of financing the health structure in Texas will continue to be a priority. The challenge of this environment will be a focus of next year's five year needs assessment and may lead to addressing changing needs in a dynamic environment.//2004//

***/2005/Knowing how Texas compares nationally is critical as Texas conducts its 5-year needs assessment. This is especially crucial during the transformation of Texas' HHS systems and while the implementation of legislative mandates continue in an environment that remains resource-and capacity-challenged. The 04 Kids Count Data report provides an overall summary of 10 key health indicators for all 50 states. These 10 key indicators of child well being include low birth weight, child death rate, high school dropouts, percent of children in poverty and percent of families with children headed by a single parent. Texas ranks 36th of 50 (worst), and substantially lower than other highly populated states such as Florida(34), New York(25), and California(15) when calculating an overall ranking based on the 10 key indicators. According to Kids Count 04, Texas ranks 22nd nationally in percent of low birth weight babies, 43rd in percent of teens who are high school dropouts, 27th in rate of teen deaths by accident, homicide, and suicide per 100,00 teens, and 33rd in the child death rate per 100,00 children, and 13th in infant mortality rates per 1,000 live births. In Texas, substantial room continues to exist for improvement in the delivery of services and the reaching of in-need and at-risk populations. Texas' next 5-year needs assessment will yield valuable additional data and insight to support and frame Title V activities and initiatives in coming years. //2005//***

***/2005/A discussion of the state of MCH in Texas includes a myriad of factors and issues. For a discussion on other issues including Texas' Tobacco Settlement and initiatives and as TDH's priority initiatives related to maternal and child health please see the attachment. The attachment includes discussion on obesity prevention and fitness promotion, immunization rates, and health disparities. Included is a discussion of TDH's women's health initiatives such as efforts to integrate women's health services, perinatal depression, and Texas' Healthy Start initiatives as well as an overview of CSHCN initiatives to include implementation of new program rules and the waiting list. A map of Texas' public regions, as referenced earlier, is also attached.//2005//***

## **B. AGENCY CAPACITY**

In FY02, 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, FQHCs, 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% FPL and not eligible for Medicaid and CHIP. MCH direct service providers are required to screen for Medicaid/CHIP 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.

In early February 01, Title V Program announced the availability of funds for grants targeted toward improving the health of infants, women, children and adolescents starting in September, 2001. Grant requirements were released in a 3-year competitive request for proposals (RFP) that consisted of two types: Fee-for-service direct health care and population-based infrastructure building services. Applicants could apply for both types or one type only. Currently, a total of 76 contracts for MCH fee-for-service are funded statewide for a dollar amount of about \$21 million and 15 contracts for genetic fee-for-service are supported with a total of \$1.5 million for array of allowable Title V services categories). In addition, 37 population-based contracts were awarded for a total of \$2.3 million. For FY 03, approximately the same number of contracts will be funded for the second-year continuation of the 3-year competitive RFP. As a result of the Title V budget realignment, contract amounts will be reduced by approximately \$1.7 million (see Section 3.3.2 Other Requirements under Texas Title V Budget Realignment).

/2004/ FY 03 began the second year of a 3-year competitive request for proposals (RFP) that consisted of two types: fee-for-service direct health care and population based infrastructure building services. Only current contractors were able to apply for grants to improve the health of infants, women, children and adolescents starting in September 02. FY 03 was the first year that MCH (prenatal, child health, children's dental, dysplasia) were awarded separate from family planning services funded by Title V. As a result of the Title V budget realignment, contract amounts were reduced from FY02 awards by approximately \$1.7 million. A total of 76 contracts for MCH fee-for-service continue to be funded statewide for a total dollar amount of about \$12 million, 54 contracts for family planning for a total of approximately \$8.1 million, and 15 contracts for genetic fee-for-service for a total of approximately \$1.5 million. In addition, 27 population-based contracts were awarded for a total of \$1.6 million. There are nine fee-for-service genetics contractors, for a total of \$1,342,000; and three populations based genetic service contracts, for a total of \$158,000. //2004//

***/2005/As in similar years, funding of contracts to improve the health of infants, women, children, and adolescents is a key component of Texas' Title V Program. FY 04 began the 3rd and last year of a 3-year competitive request for proposals cycle consisting of 2 types: fee-for-service direct health care and population-based/infrastructure building services. Only current contractors were eligible to apply. As a result of this process, direct maternal-child health services are provided through 75 contracts statewide for a total of \$10.5 million. A total of 55 contractors providing family planning services received an additional \$7.1 million. TDH also awarded 8 genetic fee-for-service contractors totaling \$1.1 million and 2 genetic populations-based contracts totaling \$106,000. A total of 23 population-based/infrastructure building contracts, addressing a range of health disparities for minority groups and groups living in rural areas in Texas, were awarded totaling approximately \$1.1 million. TDH anticipates maintaining level FY 04 funding for FY 05.//2005//***

/2004/ Provision of MCH services in Texas continues. Protecting the health of all Texans, including women and children, is at the core of the Department's mission. Services provided by women and children focused programs in a multi-tiered system of infrastructure building services, population based services, enabling services and direct services is a hallmark of the delivery of health services in Texas. For example, the BWH, while not currently involved in the provision of direct services, other

than through family planning contractors, has a very strong focus on building capacity of systems to meet the need by development of policies, guidelines and programs addressing the public health needs of their targeted population. Both clinic and non-clinical staff have and maintain a high level of expertise in their chosen fields. BWH staff stay current, leverages resources and links individuals and organizations to relevant programs by establishing, maintaining and fostering both existing and new national, state and local relationships. BWH provides data, data analysis, information, guidance, technical assistance and training to its stakeholders by various means (in person, phone, email, Internet). As with all levels of national, state and local government staff is adapting to workforce and workload issues, and finding creative, lower cost ways of meeting needs.//2004//

***/2005/As Texas heads into a new funding cycle with the FY 05 application and with the coming 79th Texas Legislative Session, TDH Title V staff continue efforts at maximizing available Title V funds and the activities and outcomes they support. Efforts include a reassessment of how Title V funds regional population-based activities. Currently, Title V staff are evaluating how current population-based fund dollars are used and how they might be best used in the future to achieve maximum impact. Future efforts may include funding specific and prescriptive population-based activities and interventions in demonstrated need areas, in conjunction with regionally determined population-based needs and activities. Focusing population-based efforts and allocation of resources for example on specific activities designed to affect immunization, obesity, and tobacco prevention, may yield health outcomes not maximized by current exclusive local/regional determination of population-based focuses and the activities that support them. This effort will take into consideration the outcomes of the ongoing health and human regional structures project, as part of the HB 2292 transformation, to develop a single set of regional boundaries for the entire health and human services system. Presently, TDH and Title V program operate within a structure defined by 11 public health regions. The current 11 PHR structure will probably change as a result of the ongoing HHSC transformation. //2005//***

## Women's Health

/2004/TDH was also awarded a HRSA grant (September 02) to implement a 3-year Texas Comprehensive Women's Health Initiative. The initiative's purpose is to enhance the state's capacity for promoting the integration of women's health services for priority populations. During the grant's first year, BWH established a formal planning workgroup for women's health at the state level and initiative and began efforts supporting development of two women's health services planning workgroups at regional levels. Pilots in two areas of the state, El Paso (Region 10) and PHR 11 (Rio Grande Valley) will increase the capacity of providing local leadership and decision making leading to anticipated improvement in the integration of services for women.

Maintenance of ongoing collaborations and the enhanced capacity they afford will continue to be critical to the successful delivery of maternal and child health services in Texas. An important link in Texas capacity to provide services is ongoing collaboration and development of a stronger collaboration between Healthy Start and Title V. As TDH and Healthy Start mutually identified mutual goals of improving perinatal health outcomes for mothers and children, together they identified activities designed to increase collaboration. Activities planned for FY 04 include holding quarterly meetings for continued planning and collaboration (information sharing, issues discussions, etc), Healthy Start input into the BWH's perinatal systems planning and rules development and implementation, Title V supports the San Antonio Health Start's project in planning for the FY 04 conference focusing on pre-term birth as well as together participating in the implementation of the Region VI 3-year strategic plan. //2004//

***/2005/During FY 04, additional collaborations included Title V women's health staff working with the March of Dimes on resource allocation and on the 5-year campaign to prevent prematurity and working with the Texas Medical Association (TMA) on projects such as a letter from physicians to encourage employers to support female employees who desire to pump breastmilk during the work day. Title V staff are also working with TMA, the Texas Association of Obstetricians and Gynecologists and with the Postpartum Resource Center of Texas to form***

***the American the American College of Obstetricians and Gynecologist Provider Partnership on perinatal depression and related mental health issues.//2005//***

Children's Health

/2004/The Child Wellness Division (CWD) programs has aided in providing capacity to provide for and protect the health and safety of all children in Texas has primarily been provided in the past through contractors who tailor their programs for their specific communities. Many CWD programs promote prevention and early childhood intervention through education, many of which are local based. Funding reductions have eliminated many worthwhile programs (i.e., youth health initiative) the local level. However, grants such as Healthy ChildCare America will hopefully sustain an infrastructure for programs that can be further developed in the future. Programs in the CWD (School Health, Adolescent Health, Audiology Services, Traffic Safety, Take Time For Kids, Vision/Hearing Screening and Abstinence Education) also engage and partner in proactive collaborations with a variety of partners. The most aggressive program to initiate and support collaboration/coordination has been the Take Time for Kids Program as detailed in other sections of this application. Also, a number of school health staff members have been actively involved on various internal workgroups that involve TDH areas (i.e., nutrition, obesity, physical fitness, diabetes, immunizations, etc) to develop plans and implement strategies to further support the health and safety of children both within school settings as well as within Communities. The Newborn Hearing Screening program collaborated with the Texas Interagency Council for Early Childhood Intervention in applying for a grant from CDC-P to enhance the Texas Early Hearing and Detection and Intervention program to increase the number/percentage of infants who receive follow-up outpatient screening and enter intervention services by 6 months of age. Word on whether this application is funded will arrive in Summer 03.//2004//

***//2005/ This grant activity was not funded.//2005//***

***//2005/Over the course of the last several years, HHSC in collaboration with TDH Title V staff and other partners, have implemented various activities to strengthen the capacity of HHS agencies to provide efficient and effective early childhood services. Senate Bill 665 of Texas' 77th Legislature established the Office of Early Childhood Coordination (OECC). OECC goal's include promoting community support for parents of all children younger than 6 years of age through an integrated state and local level decision making process and providing for the seamless delivery of health and human services to all children younger than 6 years of age to ensure that all children are prepared to succeed in school. Other duties of OECC include identifying gaps in early childhood services, state policies that prevent children from accessing available service, exploring courses for public and private funding and seeking enhanced collaboration opportunities.***

***The creation of and the work of this office provide an opportunity to enhance Texas' HHS capacity to coordinate and integrate service delivery for all children under age 6. Currently, programs for children are housed in various agencies and other locations, often with little or no collaboration. Some programs target subsets of the 0 to 6 population, others serve much larger populations. When SB 665 was enacted, there were over 50 programs in HHS agencies providing services for children under age 6, with combined federal and state FY 01 expenditures of approximately \$3.89 billion.***

***The OECC created a statewide strategic plan entitled "Texas Young Children, Their Future, Our Plan". This plan can be viewed at [http://www.hhsc.state.tx.us/si/oecc/oecc\\_home.html](http://www.hhsc.state.tx.us/si/oecc/oecc_home.html). OECC Advisory Committee members, in whom the Title V Office is represented, assisted TDH Title V staff in writing the application for the HRSA funded State Early Childhood Comprehensive Systems (SECCS) planning grant. TDH received the SECCS grant in July 03.***

***As has been stated in previous sections of this application, Texas is undertaking a major overhaul of its 12 existing health and human state agencies by consolidating the duties and functions of these agencies into a single new HHS enterprise comprised of HHSC and 4 departments. This overhaul calls for a fully coordinated and integrated service delivery for all***

**children under 6 years old. The OECC has been established at HHSC to carry out this responsibility. Since the OECC and the SECCS Grant share the same goal and objectives, it was reasonable to transfer the grant's oversight and administration to the OECC. Title V involvement through its resources and funding towards OECC and SECCS grant remains unchanged and is delineated in the intra-agency cooperation agreement between TDH and the OECC.//2005//**

/2004/Dental Health and Treatment -- Capacity

Addressing the issue of capacity, TDH must consider the state's capacity to deliver dental services. Coupled with an already existing shortage of dental providers willing to provide services to the those not on private dental insurance and/or private pay patients, several changes were made this legislative session that may dramatically impact the state's capacity to provide access to dental services for Texas' children. For example, the Division of Oral Health's (DOH) budget was reduced by 68% for the FY 04-2006 biennium, leading to almost a 75% staff reduction. Some services such as fee for service dental will be completely eliminated while others, such as proactive education, will be eliminated except for basic oral hygiene instruction given during exams and/or treatment. The DOH also helped establish the original Texas CHIP for dental by assisting in setting rates and policies, however due to a legislative mandate dental coverage for children in CHIP was eliminated. As a result, some Title V monies have recently been redirected to help with establishing an infrastructure of a Texas dental services in each region. In addition, dental services will continue to be provided through Title V-funded contractors.//2004//

**/2005/Public input on maternal and child health issues continues to be an important component of Texas Title V program and its operations. FY 04 activities include Title V staff participation in development of the State Oral Health Plan. The University of Texas Health Science Center-Dental School received a grant from HRSA to develop this plan. Five listening sessions were held across the state and oral health advocates, consumers and other stakeholders gave testimony or made presentations on the issues relevant to oral health. The sessions have been well attended and included compelling testimony or presentations on the issue. By 9/04, a State Oral Health Plan Steering Committee, including the State Title V Director, will develop a draft plan that includes the input from the listening sessions for presentation to agency leadership and statewide policy makers.//2005//**

Service Delivery Integration

/2004/How we provide services today to an every increasing client base in a resource static environment remains a challenge that Title V must work to meet. One important effort is that of service delivery integration. //2004//

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 required. 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" 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 Family Health was identified as the lead for implementing the service delivery integration (SDI) directive.

Service Delivery Integration began by integrating, streamlining, and standardizing policies and procedures of several programs. To support the integration of policies, an automation system, SDI Integrated, Eligibility, and Reporting System (SIEBRS), was developed. A streamlined, integrated contract procurement process for the including a single contract attachment for in-scope programs

was also utilized.

*/2004/The SDI project currently maintains 5 pilot contractors (Denton County, Hidalgo County, and Tarrant County Health Departments, Fayette Memorial Hospital and the Tyler-Smith Public Health District. In-scope programs are Titles V, X, XX, Primary Health Care and TB Elimination. All pilot contractors offer Title V services, but not necessarily all of the in-scope programs. SDI contractors for FY 04 will be renewed. Recently completed activities in this area include continued revision and streamlining of integrated policy manual and business rules for integrated IT systems. By March 1, 2004, because of the accomplishments realized during this pilot, such as reduction in administrative burden and better accountability, the plan is to expand this initiative to all primary health care contractors and eventually to include all contractors such as Title V. //2004//*

*/2005/In FY 04 Service Delivery Integration (SDI) staff, with SDI pilot contractors' collaboration, have continued to refine the automated integrated, eligibility and reporting system and have further developed both the Medicaid recoupment mechanisms that enable SDI to identify clients who are SDI eligible and later become Medicaid eligible clients. SDI then recoups the SDI payments made to the pilot contractors who, in turn, bill the Medicaid program.*

*For FY05, SDI participated in the Request for Proposals (RFP) competitive process for the Associateship of Family Health. SDI asked for contractors who would be interested in participating in the SDI business process. All 5 current SDI contractors enthusiastically requested to continue with SDI. A total of 22 volunteered and 12 were selected including 4 of the current SDI contractors. One current contractor did not receive funding from an in-scope program and will not participate next year. The 12 contractors were selected primarily so SDI could have a representative sample for an evaluation in FY05. Selection criteria included: geographical, volume of clients served, rural/urban, funding source/program recommendation and their consent to use the SDI business process in FY05 and participate in the evaluation. The SDI initiative will be evaluated in FY 05 for efficiencies and effectiveness including how well it has met the legislative charge of decreasing administrative burdens to the client, contractor, and TDH. Simultaneously, the next steps are to start incorporating lessons learned from the SDI/SIEBRS eligibility pilot model into TWICES (Texas Wide Integrated Client Encounter System), which is the platform of an integrated system of all TDH direct public health services including client register (demographic), immunizations, primary health care, maternal and child health care services, family planning and tuberculosis elimination services. Once TWICES is fully operational, including screening, eligibility, billing, and reporting functions, SDI/SIEBRS will be phased out. //2005//*

*/2005/An important aspect of capacity in Texas is the availability of and access to services. Federally Qualified Health Centers (FQHC's) play an important role in providing services to women and children in Texas. Texas currently has 40 FQHC organizations that operate approximately 161 clinic sites throughout the state. During FY 04, TDH implemented the FQHC Incubator Grant Program. This grant-focused program made grants to establish new or expand existing facilities that can qualify as FQHCs. The FQHC Incubator program includes 4 phases: 1) Planning grants support feasibility studies or development of specific FQHC application sections such as, the health or business plan as well as supporting collaborative planning between organizations; 2) Development grants provide support for developing the organizational and collaborative capacities required of FQHCs, as well as grant application development, training, and some staff support; 3) Transitional operating support grants focus on providing resources to operationalize community-based clinics increasing the likelihood of receiving federal funds; and 4) Capital Improvement grants support the infrastructure of existing FQHCs and FHQC Look-Alikes.*

*Each successful grant applicant enters into a contract with TDH that specifies a schedule of payments and the benchmarks they must achieve for continued funding at each stage. The Texas Primary Care Office, under the supervision of the State Title V Director, provides technical assistance and grant administration relative to this initiative. TDH's goal is to assist 17 organizations in Texas in receiving new or additional federal funding as an FQHC or*

***federally certified FQHC Look Alike status.***

***To date in FY 04, TDH has released 2 FQHC Incubator Grant Requests for Proposals (RFP) for a total of \$5 million. Currently, there are 43 current FQHC incubator grantees. Grant recipients are statewide and vary in community size and location.***

***The outcome of this initiative has been promising. To date, a total of 4 new applications were submitted to HRSA; 14 communities are in the process of applying for FQHC Look-Alike Certification and 4 communities have indicated they will be submitting applications this year to HRSA for full FQHC funding.***

***Funding will continue in FY 05. The RFPs will continue to emphasize the development of an organization and health plan meeting the requirements for federal funding. TDH is seeking additional state funds to cover this initiative's administration expenses for at least the first year of the upcoming biennium in order to align with the final year of the President's initiative for FQHC expansion. //2005//***

In addition, the 78th Legislature appropriated \$23.4 million for the FY 04-05 biennium, or \$11.7 million per year, for the delivery of direct primary health care services. The legislative intent for the Primary Health Care program is to continue the provision of primary health care services through the implementation of a new service delivery model. Under this model, funding awards will be made through an allocation formula to counties with communities located in medically underserved areas having a high number of uninsured and a disproportionate burden of health disparities. The goal is to implement this program by March 1, 04.

***//2005//FY 04 began the 3rd and final year of a competitive request for proposals (RFPs) for the delivery of primary health care services. Fifty-six contractors were awarded about \$12 million to provide direct primary health care services to low-income Texans reside in 134 of Texas' 254 counties. Based on input from primary care stakeholders, TDH decided to continue to make available awards through a RFP model directly to local providers. FY 05 begins the next competitive RFP cycle and TDH anticipates that the current funding level will support an increased number of providers and counties served. //2005//***

Both of these programs, Primary Health Care program, and the FQHC Incubator Initiative, have been placed under the oversight of the State Title V Director. This will provide further opportunities for streamlining and integrating policies and procedures from different safety-net programs affecting the MCH population. //2004//

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.

#### Children with Special Health Care Needs Services

TDH and Title V operate the CSHCN Services Program. The services provided through the CSHCN Program were changed as of July 1, 2001 to remove diagnosis-specific requirements and move toward a health benefit plan more like CHIP. Services are available for children from birth until 21 years of age (except adults with cystic fibrosis, who are eligible for services beyond age 21) who meet financial guidelines and residency requirements. Citizenship and documented immigration status are not required.

The CSHCN Services Program provides health care services including: early identification, initial evaluation and diagnosis; case management, physician visits; hospitalization; orthotics and prosthetics; medical equipment and supplies; nutritional supplements; nutritional counseling; medications; speech, language, physical, and occupational therapy; and meals, lodging, and transportation to receive medical treatment.

The CSHCN Services Program recently underwent a major redevelopment process as discussed in previous sections. Redevelopment has resulted in a program that is open to children meeting the definition of a "child with special health care needs" and not just a specific diagnosis; 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 also plans to offer an array of family supports, such as respite, when funds are available and currently is maintaining a waiting list for family support services. The CSHCN program will continue to be the payer of last resort, after Medicaid, CHIP, and private insurance.

A waiting list for medical benefits in the CSHCN Program has recently been instituted due to an unanticipated budget shortfall. To address further this budget shortfall, TDH asked the HHSC to conduct an independent review of the program. A five-member team was appointed. Team members interviewed over 60 individuals and conducted an extensive financial analysis leading to a set of 18 recommendations involving administrative functions, contracts and grants, medical services, and financial management of the program. If totally implemented, cost savings in FY02 would be \$5.6 million and \$8.1 million in FY 03. TDH appointed an 11-member implementation team, including stakeholder representatives from the CSHCN Advisory Committee to review the recommendations and develop a plan for implementing them.

Some of the review team recommendations have already been implemented. For example, reductions in staff have occurred, and, as mentioned, a waiting list for new clients seeking services for medical and family support services has been established. The current scope of health care benefits and family support services are set forth in the program rules which were developed in a time when it appeared there was more funding available for the program. To reduce or limit the program's health benefits and family support services requires program rule changes. To that end, the implementation team is in the process of drafting new program rules. Further efforts to address the budget shortfall include assessing and analyzing the possibilities of contracting in existing risk arrangements with health plans in larger groups (Medicaid, CHIP) to improve the risk rating for this group of clients, and the establishment of a separate nonprofit CSHCN foundation.

/2004/ The Texas Board of Health approved the CSHCN program rules that became effective on March 27, 2003. The rules, as mentioned earlier, were changed to establish a detailed process by which the CSHCN Program shall align its budget annually, especially when the estimated amount of funds needed by the program exceed the appropriated funds and other available resources. The rules now include methods for the program to use in placing children on the program's waiting list and the criteria and protocol to determine "urgent need for health care benefits" so that they may be taken off the waiting list if funds become available. Currently the program has approximately 1,200 children on the waiting list. The impact of the rule changes on the program's clients is that there is now a clarified public process for placing children on and off the waiting list for services.

An intensive effort is now underway by CSHCN staff to operationalize the rule changes. Approximately 30 rules implementation issues were identified and at a meeting of the CSCHN program leadership, issues were grouped into 6 areas: Definitions and Eligibility; Family Support Services; Case Management; CSHCN Advisory Committee; Budget Alignment; and Quickly and Simply Resolvable (includes those issues that require little or no change, but do need someone to make sure that they conform to the new rules). Team leaders have been assigned to each of the areas and teams formed of cross programmatic representation, representatives from case management, representatives from Information systems, and representatives from TDH regional offices. Each team developed a work plan identifying the steps needed to address their respective issues and a timetable to complete. A Coordination Group meets weekly to insure that work by the teams is supported across all areas and that work plans are integrated. //2004//

***/2005/CSHCN Program's extensive process for operationalizing new program rules resulted in many minor changes to existing policies and the adoption of 10 major new and/or substantially amended policies. These changes and additions provide a clearer, more consistent methodology for adding and removing clients to and from the waiting list. Program***

**costs are closely monitored and expenditures more accurately predicted, resulting in moving over 1,300 children from the program's waiting list. As of May 04, fewer than 100 clients remain on the CSHCN program's waiting list.//2005//**

**/2005/Additional capacity issues such as CSHCN case management, systems of care, Medicaid managed care, and others are covered in the attachment.//2005//**

## **C. ORGANIZATIONAL STRUCTURE**

TDH is the state agency responsible for administration of the Title V Program and is 1 of 13 state health and human services agencies under the umbrella of the Texas Health and Human Services Commission (HHSC). 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 commissioner. 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.

/2004/The existing organizational chart for HHSC is available at [http://www.hhsc.state.tx.us/about\\_hhsc/hhsc\\_org.html](http://www.hhsc.state.tx.us/about_hhsc/hhsc_org.html). //2004//

/2004/ How health and human services will be organizationally and administratively aligned was dramatically changed during the 78th Legislative Session. By mandate of HB 2292, the Governor and Legislature directed Texas health and human service agencies to consolidate organizational structures and functions, eliminate duplicative administrative systems, and streamline process and procedures that provide the delivery of health and human services to Texans. Currently, health and human services are provided to millions of Texans through an array of services with a sometimes complex and confusing framework of policy-making, management and administration, and delivery systems. At present, 12 separate agencies, expend an estimated \$19.5 billion per year to administer over 200 programs, employ about 50,000 state workers, and operate from over 1000 different locations across Texas. The policy changes in this bill are designed to contain rising health care costs while ensuring that the most needy Texans continue to receive essential services. The major provisions of HB 2292 are:

\*Agency Consolidation -- Operations of the 12 existing health and human services agencies will be realigned by consolidating functions in 4 agencies with oversight by HHSC. Those agencies are Department of State Health Services, Department of Aging and Disability Services, Department of Assertive and Rehabilitative Service and the Department of Family and Protective Services. Administrative and eligibility functions will be consolidated into HHSC. TANF policy responsibility transfers to HHSC and all advisory committees (unless mandated by federal law and/or executive commissioner mandate) are abolished. Most TDH programs, including most Title V programs will become part of the Department of Health Services.

\*Oversight and Accountability -- A governor appointee serves as HHSC executive commissioner. A commissioner appointed by the executive commissioner and approved by the Governor will supervise each of the other 4 entities. A council of 9 gubernatorial appointees will be created for each agency to advise the agency commissioner on agency policies and programs. Commissioners of the individual agencies will develop rules for their respective agencies, with final authority to adopt rules for each HHSC agency.

\*Transition to Consolidated System -- HHSC is responsible for developing a transition plan by

December 03 to reflect the initial vision and timelines for the consolidation. Full consolidation is anticipated to take between 4 to 6 years. Some of the consolidating and streamlining efforts have already begun, such as the consolidation of all human resource functions from multiple agencies into HHSC as well as the migration to a common automated system for accounting and administrative transactions

\*Transition Oversight and Public Input -- A legislative oversight committee will be created to facilitate the consolidation with anticipated minimal disruption of services and to provide ongoing guidance. The committee will solicit public input in the development of the transition plan and will hold a public hearing(s) on the plan no later than November 1, 2003. The final plan is due to the Governor and Legislative Budget Board no later than December 1, 2003.//2004//

***/2005/ As noted in the State Overview Section of this application significant mandated transformation of the health and human services system organizational structure and the programs and populations served by that structure, is underway. This transformation will impact how services are delivered and will impact how agency staff collaborate and cooperate to reach like populations.***

***As of Sept. 1, the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse and the mental health sections of the Texas Department of Mental Health and Mental Retardation merge to become the Department of State Health Services (DSHS). The organizational design for DSHS is attached to this section. One rationale for the organizational design is that in the new DSHS organization common functions of the 3 agencies are aligned into coordinated program divisions, facilitating an integrated approach to providing services and ensuring that clients can find and access needed services. These functionally-focused divisions include Mental Health and Substance Abuse Services, Family and Community Health Services, Prevention and Preparedness Services and Regulatory Services. The Family and Community Health Services Division includes Community Health Services, Specialized Health Services, such as the CSHCN program, and Nutrition Services. The Texas State Title V Office resides in the Family and Community Services Division and also funds initiatives and programs across and outside the agency. This transformation is ongoing and affects many Title V programs and activities. This transformation will serve as part of the environment under which Texas conducts its next 5-years needs assessment. The early affects of implementation will be detailed in Texas FY 06 application. //2005//***

TDH Organization.

There have been major changes in key agency personnel and organizational structure since the last submission of the Block Grant Application:

***/2005/ Though dramatic organizational changes as detailed earlier in this application are pending for FY 05, during FY 04, TDH's organizational structure remains essentially the same and can be viewed at <http://www.hhsc.state.tx.us/Consolidation/News/OrgMeetings.html>. A few key personnel changes are noted in the following sections. //2005//***

On November 5, 2001, Eduardo Sanchez, M.D., began his tenure as Texas Commissioner of Health. Prior to his appointment, Dr. Sanchez was an Austin family practice physician and health authority for the Austin-Travis County Health and Human Services Department. Dr. Sanchez replaces William R. Archer III, M.D., who resigned in October 2000. Texas Department of Health (TDH) Executive Deputy Commissioner Charles Bell, M.D., performed the duties of the commissioner of health during the interim.

Following these appointments and with the TDH Board of Health approval, TDH reorganized its programs into three Associateships: Associateship for Disease Control and Prevention, Associateship for Family Health, and Associateship for Consumer Health Protection. All 3 associateships report to the Deputyship for Programs under the leadership of the Deputy Commissioner for programs, Ms. Debra Stabeno. Ms. Stabeno reports to the Executive Deputy Commissioner, Dr. Charles Bell Within

the Deputyship for Programs, the Title V is located in the Associateship for Family Health. Ms. Debra Wanser became the Associate Commissioner for Family Health, effective January 02. Ms. Wanser served as State Title V Director for about three years. Dr. Fouad Berrahou was selected as the State Title V Director effective July, 02. The Associateship is comprised of 5 bureaus and 1 division under the Associate Commissioner. The bureaus are: Bureaus of Support Services, Nutrition Services, Children's Health, Women's Health, Kidney Health Care. And the Title V Systems and Processes Development Division. 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 coordinate and collaborate across programs effectively.

The Support Bureau includes 5 divisions that support all of the Associateship programs and activities: Financial Management, Research and Public Health Assessment, Quality Assurance and Monitoring, Automation Planning, and the Health Communications Division.

The Bureau of Nutrition Services includes the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Farmer's Market Program; Public Health Nutrition Program; and Electronic Benefits Transfer. Mr. Mike Montgomery is the Bureau Chief and State WIC Director.

The Bureau of Children's Health (BCH) is made up of 5 divisions that include the Children with Special Health Care Needs, Child Wellness; Genetics and Case Management; Oral Health Services, Texas Health Steps Division (EPSDT) and Medical Transportation Program; and Information and Referral Line for Maternal and Child Health programs. Ms. Jann-Melton Kissel is Chief of the BCH.

The Bureau of Women's Health includes the Division of Family Planning (Titles V, X, XIX, and XX), Women's Health Laboratory, Division of Breast and Cervical Cancer Control Program (moved from Bureau of Chronic Disease), Maternity and Perinatal Health Office of Special Projects which includes the Texas Breastfeeding Initiative, Domestic Violence Prevention Program, Male Involvement Project, Osteoporosis Program, and Office of Women's Health. Ms. Margaret Mendez was named Bureau Chief in December, 1999.

The Title V Systems and Process Development Division includes the general administration of the State Title V Program, Primary Health Care (PHC) Contracts Program, and the State County Indigent Health Care Program. As part of the last realignment, the PHC Program and the County Indigent Health Care Program moved under the Title V Division Director. This offers opportunities to streamline both Title V and PHC, along with Titles X and XX contractual policies and procedures. The State Title V Director has the responsibilities of managing the Title V Systems and Processes Development Division and reports to the Associate Commissioner for Family Health.

/2004/ Leadership and organizational reporting transition at TDH continued during FY 03. In March 03, Dr. Nicholas Curry was appointed to serve as Acting Executive Deputy Commissioner, replacing Dr. Charles Bell who took a position with HHSC. Previously, Dr. Curry served as the Director of TDH Public Health Region 1. His duties included coordination and oversight of the delivery of comprehensive public health services in 41 counties, developing and supporting community health partnerships, and managing regional resources.

Prior to coming to TDH Dr. Curry served as the principal for CCA Health Systems providing consultation on health systems management, health policy, health risk communications, and health organizations management. He has also served as the President and CEO of the Community Health Foundation of Tarrant County; Inc. Dr. Curry was the Director of Public Health for Tarrant County Health Department and Fort Worth Health Department after serving as the Chief for Clinical Services for the Houston City Health Department.

Dr. Curry holds a Master of Science degree from the University of Georgia and an M.P.H. from the University of Alabama. He received his medical degree from Baylor College of Medicine. He is Board Certified in Public Health and General Preventive Medicine, and in Quality Assurance and Utilization Review. //2004//

/2004/Sam Cooper was selected as CSHCN Division Director in April 03 and brings a range of experience in social work, quality assurance and public health to this capacity. Dr. Lesa Walker

served as Acting Director until Mr. Cooper's selection and continues to serve as the CSHCN Title V Director. //2004//

***//2005/Personnel changes related to the HHS transformation have begun to take place at TDH, soon to be the Texas Department of State Health Services. Executive level positions have begun to transition and several of those positions are covered in the attachment to this section.//2005//***

## **D. OTHER MCH CAPACITY**

Attachment 1, Table 1 provides 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 FY 03 as of June 03. Table 1 of the attachment shows a total of 244 positions funded in the Associateship for Family Health (TDH Central Office in Austin) with federal Title V and state general revenue funding. Table 2 shows a total of 340 positions funded with federal Title V and state general revenue funding in TDH's 11 public health regional offices.

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 managers 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. Managers 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, and 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.

***//2005/The attachment is updated, based on May 04 budget figures, to show the number and types of full-time equivalent personnel funded by the federal-state Title V program in both the TDH Central Office in Austin, as well as Texas' 11 Public Health Regions (PHR). Table 1 shows a total of 258 positions Austin-based federal and state funded positions in FY 04, a slight increase as compared to 244 FTEs in FY 03. Table 2 shows a total of 238 FTEs similarly funded in TDH 11 PHRs. This is a significant decrease of 102 FTEs from the 340 positions funded in FY 04. Several factors influenced the number of FTEs funded by state and federal Title V funds. One factor is a significant number of retirements, influenced by a legislatively mandated 25% 1-time payment retirement bonus. Other factors include realignment and reclassification of positions to better meet the legislatively mandated management-to-staff ratio of 1:9. //2005//***

The attachment also contains summaries of the qualifications of senior level employees (Item 3), including Executive Deputy Commissioner, Associate Commissioner for Family Health, Chiefs for the Bureau of Children's Health, the Bureau of Women's Health, the Bureau of Nutrition Services, and the Bureau of Support Services, and both Title V MCH and CSHCN Directors.

Currently, 11 parents of CSHCN and advocates 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 joined the program in July, 2000.

/2004/ The parent consultant participated in reviewing the program's rules and requests for proposals for new initiatives and the Title V Block Grant Application, but due to budgetary constraints, is no longer funded by the program. Consumer members of the CSHCNAC continue to provide support in this area as well. //2004//

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 78 members for all MCH and CSHCN advisory committees; of those, 30 members are consumers and/or advocates. A summary of the CSHCN and other MCH-related advisory committees is listed in the attachment, Table 4.

/2004/ HB 2292 of the 78th Legislative Session limits the role of advisory groups in health and human service agencies to only those mandated by federal law (e.g., Family Planning Advisory Committee) or those determined essential by the HHSC commissioner. TDH values stakeholder input and is currently working to identify ways to keep or reorganize these groups to ensure opportunities for stakeholder input. There are now 38 members who are consumer and/or advocates. //2004//

The organizational relationship of the Texas Department of Health to the other health and human services has been described in Organizational Structure. Title V staff within the Associateship for Family Health 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.

/2004/ The 78th Legislative Session appropriated \$10 million for the FY 04-05 biennium, or \$5 million per year, to maximize federal resources and increase the provision of health care services to uninsured and medically underserved populations throughout the state. This funding will provide seed money to expand the number of new sites operated by new or existing community health centers. TDH is in the process of creating a Federally Qualified Health Center (FQHC) Incubator Grant Program to position strategically clinics to apply for and receive support as FQHCs.

***/2005/ With this year's application the discussion on FQHC's has been moved to the Agency Capacity Section.//2005//***

In addition, the 78th Legislature appropriated \$23.4 million for the FY 04-05 biennium, or \$11.7 million per year, for the delivery of direct primary health care services. The legislative intent for the Primary Health Care program is to continue the provision of primary health care services through the implementation of a new service delivery model. Under this model, funding awards will be made through an allocation formula to counties with communities located in medically underserved areas having a high number of uninsured and a disproportionate burden of health disparities. The goal is to implement this program by March 1, 2004.

Both of these programs have been placed under the oversight of the Title V Director. This will provide further opportunities for streamlining and integrating policies and procedures from different programs affecting the MCH population. //2004//

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.

## E. STATE AGENCY COORDINATION

The organizational relationship of the Texas Department of Health to the other health and human service agencies has been described in the Organizational Structure Section. Title V staff within the Associateship for Family Health 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.

*/2004/As noted in the organization structure section, HB 2292, 78th Texas Legislature, will have significant impacts in this area. specifically in the areas of agency consolidation; oversight and accountability; transitions to consolidated systems; and significant oversight by legislators on the transition and extensive public input. Implementation of this mandate should likely improve interagency collaboration. //2004//*

***/2005/As noted in earlier sections of this application, HB 2292 has resulted in substantial change in Texas health and human services systems. On Sept. 1, 04, TDH, currently the State Title V agency, will become a new agency, the Texas Department of State Health Services (DSHS). DSHS will continue most of the activities now done by TDH and will add services and programs of the Texas Commission on Alcohol and Substance Abuse and the mental health services and programs now provided by the Texas Department of Mental Health and Retardation. These changes and consolidation will have a positive impact on integrating services and programs focusing on similar populations, including both the MCH and CSHCN populations, with more cooperative and collaborative efforts taking place as afforded by the new organizational structure.//2005//***

### 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:

Healthy Start Projects and the Title V MCH Program will continue holding 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-EPSTD), Children's Health Insurance Program (Title XXI), Texas Healthy Kids Foundation, HIV/STD Program and WIC. Title V MCH Program will continue 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.

Healthy Start Projects will continue participating in planning and developing a "Women's Health Agenda" (a statewide initiative, coordinated by TDH, Bureau of Women's Health).

Healthy Start Projects will continue providing input to the Bureau of Women's Health in planning and implementing the Perinatal Regionalization Rules in FY 2003. The Healthy Start Projects could provide leadership and be key participants at the regional level.

Under the leadership of the Region VI HRSA Office and the Healthy Start Projects, The Bureau of Women's Health staff is providing support to the San Antonio Healthy Starts project in planning for the FY 2003 conference focusing on postpartum depression.

The Texas Title V Program and the Texas Healthy Start Projects will continue participating in development and implementation of the Region VI 3-year strategic plan.

/2004/There are several ongoing projects that Texas Title V staff works with in collaboration with the Texas Healthy Start Alliance (THSA). These ongoing activities include assisting in planning for (and attending) the annual DHHS Region VI Healthy Start Conference; planning for and planning to attend the annual Texas Healthy Start education conference; Title V staff participation in the annual Healthy Start grantee meeting; planning of and participation in the quarterly THSA meetings, development of annual letters for support from the Texas Health Start projects and provision of data to the Texas Health start projects by TDH's Research and Public Health Assessment Division. Currently under consideration for FY 04 joint Title V staff and Healthy Start staff projects are a Title V staff member serving as liaison to the Ft. Worth Health Start (Catholic Charities) infant mortality workgroup. The goal of this group is to work with Healthy Start to implement their community-based approach to infant mortality and other perinatal issues in other parts of Texas. It is also proposed that Healthy Start staff collaboratively work with TDH to implement HB 341, 78th Legislature regarding parenting and postpartum counseling information and perinatal systems in Texas. Another proposed collaboration is for TDH and THSA to produce a parent education conference in January 05. Finally, TDH staff and Healthy Start staff will be working to identify Healthy Start data needs and develop a plan to provide the data to individual projects. //2004//

***/2005/Texas Title V staff and the Texas Healthy Start Alliance (THSA) continue their work on the projects outlined in FY 04. Other collaborations include a THSA representative serving on the Perinatal Systems Workgroup and on the American College of Obstetricians and Gynecologists Provider's Partnership on Perinatal Mood Disorders. During FY 04, Texas Title V staff have worked proactively to ensure that the 6 Texas Healthy Start projects are included in various activities and promotional campaigns. For example, when focus groups were scheduled for Harlingen to discuss the women's health care delivery system, the Brownsville Healthy Start was contacted to participate and to encourage its consumers to attend. When the Texas Folic Acid Council initiated a folic acid promotion using promotoras/community health workers, the 6 Healthy Start projects were included. Title V staff also work to ensure that the regional offices are connecting with the local Healthy Start projects whenever possible. //2005//***

/2004/Ongoing partnerships with other state agencies and federal agencies and partners play an important role in Title V and TDH meeting the needs of the MCH population. Some of these partnerships are detailed below. //2004//

***/2005/The Newborn Screening program actively collaborates with the Department of Protective and Regulatory Services in their attempts to locate infants with abnormal screens and to implement protocols and ensure that the baby is seen by a pediatrician, receives appropriate confirmatory testing and referral to a medical specialist for treatment.***

***The Newborn Screening program is submitted a 7/03 application for the 2005 March of Dimes Chapter Grant for enhancing genetic services related to preventable birth defects. The impact of this grant will be to reduce the number of unsatisfactory newborn screening specimens. This will result in newborns (identified with a birth defect) receiving genetic services at the earliest time possible. The grant will also promote the availability and need for genetic services for women who have been diagnosed with PKU in order to avoid maternal PKU syndrome.//2005//***

## MOU for Coordinated Services to Children and Youth

Community Resource Coordination Groups (CRCGs) for Children and Youth.

The 77th Legislature enacted legislation that strengthens and supports the work of the CRCGs of Texas whose main objective is to procure health services for children and adults who fall between the cracks and to coordinate services to children and youth who need services from more than one agency. SB 1468 calls for a joint Memorandum of Understanding between health and human services agencies, related state agencies and state-level partners to promote a statewide system of local-level interagency staffing groups (CRCGs) to coordinate services for persons of any age in need of multi-agency services.

In general, the legislation:

Updates the previous authorizing CRCG legislation for children and youth,

Adds the requirement to implement a system for CRCG for adults,

Includes the requirement to have as a standing representative on each local CRCG, a parent or family member on each CRCG for Children and Youth and/or a consumer or caregiver member on each CRCG serving adults, and

Requires a legislative report every two years to the Governor of Texas and to participating agency CEOs to report the benefits and barriers of CRCG activities.

The joint Memorandum of Understanding has been developed and signed by all 11 health and human services state agencies and other partners. TDH and Title V support both CRCGs for children and youth and CRCGs for adults. Title V social workers 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.

/2004/ During FY 2003, the total number of local CRCGs increased to an all time high of 163. This number provides access to and in each of Texas' 254 counties. A state meeting on CRCG was held for all interagency staff and many families whose children had been staffed during the year received free stipends to attend. Areas of training and consultation to the local groups were:

\*Development of interagency partnerships and effective networking;

\*Improvements in service coordination outside of the CRCG process;

\*Increased agency accountability;

\*Providing participants with the opportunity to learn about other agencies and services.

\*Increased focus upon families and fostering a sense of community.

Additionally, needs were identified for special emphasis for the coming year. These were:

Funding strategies

Attendance at local groups

Training and Technical Assistance

Public Awareness

Family involvement and empowerment

Patterns of referral

Early Identification and Prevention

Sustainability

Mobilization of Community Power Brokers

CRCG Chair and Staff Roles and Responsibilities

Redesign of Individual Staffing Teams

Wraparound Services //2004//

***/2005/ The Texas' government reorganization bill (HB 2292) abolished the CRCG state teams. An interagency workgroup, which includes representatives from the CSHCN Program, has been formed to revise the memorandum of understanding among the agencies regarding the CRCG system and provide input into the development of the biennial report to the legislature.***

***A report on the CRCG system with findings and recommendations will be submitted to the HHSC Executive Commissioner and state leaders in Fall 04 and will be reported on in the next Title V application submission. Regional staff continues participation on local CRCGs throughout the state. //2005//***

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 re-certified 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. The MOU is reviewed on a yearly basis and any changes are published in the Texas Register.

*//2004/ This interagency contract has undergone TDH management, legal and programmatic review and suggested revision and is pending renewal at this time. //2004//*

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) of the Department of Human Services.

*//2004/CSHCN staff continue collaborative work with Medicaid staff at HHSC to align policies between the two programs whenever possible. During FY 2003 policy work was concentrated on updates and revisions mandated by the elimination of local codes with implementation of the Health Insurance Portability and Accountability Act (HIPAA). CSHCN staff attended bi-monthly Medicaid Medical Policy meetings; monthly Medicaid Pricing Workgroup meetings and many HIPAA related workgroups meetings.//2004//*

***//2005/CSCHN staff continue collaborative work with HHSC to align policies with Medicaid when feasible. In FY 04, and as reported on in more detail in the current activities section, efforts have focused on the transition to a new administrative claims contractor. Other critical collaborations between BWH staff and other state agencies exist. For example, BWH staff have worked extensively with the Texas Commission on Alcohol and Drug Abuse (TCADA) on several projects including presenting information and updates at the Women's Health Network and developing the agenda for a train-the-trainer program for domestic violence that took place in May 04. BWH staff have also worked with staff from the TCADA and the Texas Department of Mental Health and Mental Retardation's Office for the Prevention of Developmental Disabilities on the development of a grant proposal for the screening, identification, and referral for fetal alcohol syndrome. During FY 03 and FY 04, Texas Title V staff have joined TCADA to establish an interagency workgroup representing over 10 state agencies on the development of a grant proposal submitted by TCADA for integration of***

**screening and referral for substance abuse among women in the health and human service system, the Texas Workforce Commission and the court system. As part of this effort, TCADA submitted a grant to HRSA for an integrated approach to addressing the issues within the context of perinatal depression. Word on whether this grant application was approved is expected in late FY 04.**

**Both the Teen Pregnancy Prevention Workgroup and the Male Involvement Program staff work collaboratively with the Texas Attorney General's Office to accomplish their work. Each year, the Breast and Cervical Cancer Control Program staff works with the Governor's Office to promote breast cancer awareness activities.**

**Impending transformation of many of Texas' health and human services agencies will further facilitate the across agency collaborations that are key to improving the health of children and women in Texas. //2005//**

#### Coordination with Other Federal Programs

The Associateship for Family Health 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.

#### Providers Who Refer Pregnant Women and Infants to Title XIX

In FY97, TDH contracted with providers across the state to provide MCH services including maternity, family planning, child health and dental services, and case management 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.

In addition, families and advocates are active in state policy and systems development as partners with the CSHCN Program 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.

/2004/Other collaborations have been detailed in other sections of this narrative and will remain an important focus as we struggle to meet increasing demands. As demands for service significantly increase, enhanced collaborations with other state agencies (including institutions of higher education), federal agencies and private partners will become increasingly important. Collaborations with and benefits of those collaborations with new partners will be a focus of the next five-year needs assessment process.//2004//

## **F. HEALTH SYSTEMS CAPACITY INDICATORS**

/2004/ Capacity of Texas' health system is a vital component of the infrastructure's ability to promote

and protect the health of women, children and CSHCN. Reviewing, and translating that review into action, of the FY 2002 Health Systems Capacity Indicators will yield important information for Title V. This information will be translated into a cornerstone of the next five-year needs assessment.

As an example, data indicate that there was an improvement from 54.7% in FY 01 to FY 02's reported 68.5% in the percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN. This improvement is related in part to an enhanced effort in case management.

Several system capacity indicators demonstrated significant increases during this five-year cycle; One in particular is HSCI 04 relative to prenatal visits. From FY 98 to FY 02 this indicator realized a 13.5% increase. Prenatal care is essential not only to the health of the mother but also to that of the child. Continuing increases in this area should impact the future health and well being of both MCH populations.

Some system capacity indicators demonstrate room for improvement in Texas' health care delivery system and will be primary focuses of the next five-year needs assessment. From FY 98 to FY 02 the percent of children hospitalized with asthma increased 7.3% from 32.2% in FY 98 to 39.5% in FY 02. This may speak to the need for more education efforts on preventive visits and the concept of medical home, as often these issues can be resolved prior to hospitalization being necessary.

Based on FY 01 data, a comparison of health system capacity indicators for Medicaid, non-Medicaid and all MCH populations in the state for low birth weight, infant deaths, prenatal care during the first trimester and prenatal care in general indicate relative consistency among all the populations when viewed in comparisons. This may be in part due to the population-based messages regarding these issues that are seen or heard by more than the intended audience.

The availability of data and the ability to analyze that data is critical to determining the needs of the maternal, child and CSHCN populations in Texas. Texas' public health data infrastructure is in solid and improving shape for this key essential public health function. Data linkages with birth and death records, eligibility files for various programs (i.e, WIC) and newborn screening files are accessible and improving. Texas has a birth defects registry and pregnancy risk assessment monitoring system that yield valuable information for planning and needs assessment activities.

Maintenance of the existing health system capacity and making improvements in that capacity will be critical as we work to provide service to more with often static or decreasing resources. Maintaining and improving this capacity will be an important element of the next five-year needs assessment and the action plans resulting from them. //2004//

***//2005/A review of Texas' FY 03 health systems capacity indicators (HSCI) again yield valuable information for Texas' Title V Program and for its maternal and child health populations. Texas' next 5-year needs assessment will be hallmarked by such data as it relates to maternal and child health populations.***

***Several system capacity indicators, with modifications made to previous years data, continue to demonstrate significant increases over a several year time span during this grant cycle. In FY 98 the reported percentage for HSCI 4 was 53.4% while in FY 03 the percentage had increased to 71.8 (a 34% increase). Prenatal care's importance for both the health of the mother and child is scientifically documented and continued increases in this area will yield valuable positive outcomes for the health of Texas' mothers and children. HSCI 02 also shows a significant increase in the percent of Medicaid enrollees whose age is less than 1 year during the reporting year that received at least 1 periodic exam. From FY 99's reported 79.3% percent to FY 03's reported 93.5%, this HSCI realized a 18% increase. This is likely due in part not only to enhanced mandated outreach efforts to this population but to improved reporting by providers of such services. A moderate increase of 7% from FY 02 to FY 03 in the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services***

**during the year may have origins in the enhanced outreach efforts and Title V efforts in stressing the importance of age-appropriate dental care. With modifications to previous year data there was even more improvement in the SSI HSCI. Data now indicated that there was an improvement from 50.8% in FY 01 to 68.5% in FY 02, again likely related to enhanced case management efforts.**

**A few of the system capacity indicators continue to demonstrate some room for improvement in Texas' health care delivery system. The increase noted last year in the rate of children hospitalized for asthma per 10,000 children less than 5-years of age continues, with a small increase noted from FY 02, 38.8 to FY 03, 39.1. Significant efforts regarding the education of providers and patients on the concept of medical home, both in the CSHCN and non-CSHCN world, will likely continue to positively impact this HSCI, as well as the enhanced outreach efforts to Medicaid families which includes information on the importance of patients establishing a medical home. The HSCI related to the percentage of SCHIP enrollees whose age is less than 1 year during the reporting period who received less than one periodic screen dropped from 2.0 in FY 02 to 1.4 in FY 03. While it is difficult to determine the reason, recent changes in Texas' SCHIP initially resulted in some client confusion that may have affected this decline. Other HSCIs not specifically mentioned in this FY 05 application update remained static from what was reported in last year's application.**

**Continued improvement in the health systems capacity is a cornerstone of the currently underway transformation of Texas health and human services system. As this transformation is implemented, and as Texas commences with its 5-year needs assessment, enhancing and monitoring this capacity and its impact on Texas' women and children will be critical. //2005//**

## IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

### **A. BACKGROUND AND OVERVIEW**

/2004/ The enhanced accountability provided by the concept of performance measures has been an appropriate and useful tool for Texas' Title V related programs and activities. During an era when budgets are constrained and all resources are tightened coupled with increasing demands for services, the performance measures have helped to frame and focus the efforts of Title V programs and the resources that support them.

During the current needs assessment cycle, a multitude of partners and stakeholders identified an overwhelming number of women, children and CSHCN needs. Using the performance measures as a framework Texas was then able to categorize the needs with a focus on the measures articulated in the seven related outcome measures.

As we approach toward the end of the five-year needs assessment cycle it is appropriate to discuss the overall progress Texas has made toward the 7 health outcome measures. Texas' outcomes have improved in this five-year cycle by realizing a decrease in the infant mortality rate in from 5.9 per 1,000 live births in FY 98 to 5.5 in 02. A moderate increase, but an indication of slow and steady progress in reducing the infant mortality rate. The ratio of black infant mortality to white infant mortality remained relatively stable during this five-year cycle, from 1.8 in FY 98 to 1.7 in FY 02. Enhanced efforts in the area of health disparities are covered in the state overview section and speak to the need to improving Texas' efforts in overcoming these disparities. The neonatal mortality rate per 1,000 births (3.5 in FY 2002) and the postneonatal mortality rates (2.5) and the perinatal mortality rate per 1,000 live births plus fetal deaths remained static over this cycle perhaps indicating the success of the systems designed to influence them. This static outcome also held true also for the ratio of black perinatal mortality rate to the white perinatal mortality rate that improved from 1.1 in FY 00 to 1.0 in FY 02. Mortality is a reflection of the health of pregnant women and the newborn and reflects the pregnancy environment and early newborn care, so we must continue to focus efforts on improving progress toward these measures.

The child death rate per 100,000 children aged 1through 14 moderately improved from 25.8 in FY 98 to 23.1 in FY 02. Activities and resources must continue to be focused on lowering the rate even further.

Texas Title V, in an environment that includes activities outside of Title V's control, has made measurable strides toward improvements in the majority of the outcome measures. Room for improvement continues to exist, and as Texas heads into the next Title V needs assessment cycle, Texas will continue to learn from past efforts and outcomes in framing future priorities over the years. Texas has continued to having proportional dollars spread dedicated towards direct health care, enabling services, population based services and infrastructure building services and will continue to do so in the future to continue on the path of improvement in Texas' MCH and CSHCN populations. //2004//

***/2005/As summarized in last year's application, Texas has generally continued to make progress toward the 7 health outcome measures. A few of the outcome measures including ones related to ratio of black as compared to white infant mortality rates, the child death rate, remained relatively constant in FY 03 from what was reported in FY 02. Others, based on FY 03 data or modifications to previous year data continued to show improvement. These improvements include Texas' infant mortality rate which continued to drop, from 6.2 per 1,000 live births in 99 to 5.6 per 1,000 live births in FY 03. All moderate increases when looked at individually, but demonstrating moderate progress when compared over a time span. Others showing improvement include the postneonatal mortality rate per 1,000 births which improved from 2.5 in FY 02 to 2.1 in FY 03 and the neonatal mortality rate showing a decline from 3.7 in FY 99 to the current FY 03 rate of 3.5. Both mortality rates demonstrate moderate progress that impacts MCH populations for years to come. The perinatal mortality rate per 1,000 live births plus fetal deaths rate showed significant improvement from the FY 02 reported rate of 9.5 to***

***the current FY 03 rate of 9.0. Continued improvements in any health outcome measure can only have positive ramifications for the maternal and child populations.//2005//***

## **B. STATE PRIORITIES**

Title V is concerned about the health status of all Texas residents. As shown in previous submissions of the Needs Assessment Section, 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 current Needs Assessment process, 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

Priority 1. To reduce the number of CSHCN in nursing facilities and other congregate care settings. Many children with activity limitations or cognitive impairments need ongoing and long-term assistance, yet some do not require institutional care. In 2002, there were about 1,228 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, 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.

***//2005/ While efforts continue at limiting the number of CSHCN requiring institutionalization, FY 03 data show that 1,141 CSHCN were institutionalized. Continued availability of family support services will make progress toward addressing the number of CSHCN in nursing facilities and other care settings. //2005//***

### Population-based Services

Priorities 2 &3. - To increase the number of children and adolescents who make healthy lifestyle choices for themselves.

- To increase the number of children and adolescents who thrive.

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. 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 2002, data revealed that 66.8% of the total population aged 13- 19 years chose healthy behaviors and 66.1% of the total population aged 0-12 years were thriving.

***//2005/FY 03 data reveal moderate increases in the percent of children and adolescents who choose healthy behaviors, from 60.1% in FY 02 to 63.4% in FY 03 and in the percent of children who were thriving from 53.0% in FY 02 to 57.6% in FY 03. Texas must continue to align public health practice and evidence-based interventions, as is core to these measures, with the quality of life of children and adolescents. //2005//***

The following are selected indicators included in the above indexes' assessment: infant mortality, low birth weight, teen pregnancy, prenatal care, motor vehicle crashes, suicide death, and homicide.

Priority 4. To reduce disparity in low birth weight rates between Black and White infants. Low birth weight is associated with increased perinatal morbidity and mortality. LBW infants who survive the neonatal period face an increased risk of continuing health problems and long- term disability. These significantly impact Texas families and the health care costs to the state. Birth data in Texas clearly show that specific populations are most affected by LBW, primarily African American families. Relative to the white population, LBW is up to twice as common for African American families.

The consequences are important if this disparity is not addressed. Texas' births will exceed 400,000 by FY 05. Texas must be able to assure adequate resources and planning for the growing number of births throughout the state. While low birth weight and other perinatal health indicators are stabilizing or decreasing statewide in Texas, LBW is not decreasing among African American families. A failure to address the large number of LBW births will mean Texas will continue to need to maintain resources to support a growing number of high-risk low birth weight births throughout the state.

***//2005/There are no significant changes from the last update of this measure.//2005//***

Priority 5. To decrease child and adolescent obesity rates. 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.

Nationally, approximately 13% of elementary school children are overweight. Data on elementary-school children in Texas for 2001 indicate:

- The prevalence of overweight among fourth-grade boys in Texas is 85% higher than estimates for the U.S. as a whole- and among fourth-grade Hispanic boys, it is 139% higher.
- The prevalence of overweight among fourth-grade girls is 63% higher than estimates for the U.S as a whole- and among fourth-grade Hispanic girls, it is 103% higher. Among fourth-grade African-American girls, it is 139% higher. (Source: TDH Innovation Grant)

Nationally, 10,5% of high-school students are overweight. Data on Texas high-school students (grades 9-12) indicate that:

- Approximately 14% are overweight.
- Males (19.4%) are more likely to be overweight than girls (8.7%).
- Minorities are more likely to be overweight than Whites. (Source: Youth Risk Factor Surveillance System, 2001)

Data on low-income, preschool children (1-5 years of age) in WIC indicate that in 2002, 24.1% were overweight. Again, the prevalence of overweight was more pronounced among minorities.

***/2005/With changes in how the prevalence of obesity is calculated Texas appears to show a considerable drop in the prevalence of obesity from 24.1 in FY 02 to 10.8 in FY 03. Prior to FY 03 Texas included children from 1 year of age up to 5 years of age and defined overweight as weight/height greater than or equal to the 90th percentile on NCHS growth charts while in FY 03 the USDA required all WIC programs (upon whose data this measure is calculated) to define overweight as children at or above the 95th percentile for BMI for weight/height/gender as plotted on the new CDC growth charts. In addition, Texas can only identify overweight as a nutrition condition on children equal to or great than 2 years of age. Studies currently underway, and in part funded by Title V, will help to further identify the true prevalence of overweight in Texas./2005//***

#### Infrastructure Building Services

Priority 6. To determine Texas baseline children's dental health status. 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 2002 TDH Statewide School Dental Survey of the School Lunch population, 8,092 third to seventh graders of 18,735 surveyed (43.2%) 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.

***/2005/Based on FY 03 data, 5,598 of the 17,874 3rd and 7th graders surveyed, or 31.3% had caries. Texas is continuing efforts at promoting sealants, providing education to both parents and providers and in collaborating in the development of a Texas State Dental Plan, all of which will likely continue to contribute to continued decreases in the incidence of carious lesions in Texas school-aged children./2005//***

Priority 7. To decrease the prevalence of relationship violence. 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%). Currently, a staff person has been hired and activities outlined for FY 2003 such as providing informational materials and web-based training will play a role in addressing this priority needs.

***/2005/There are no significant changes from the 04 update./2005//***

*/2004/An update on the performance assessment for each of the national and state performance measures is presented to this section to facilitate further an understanding of the health status of the Texas MCH population./2004//*

### C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

#### a. Last Year's Accomplishments

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers submitting

unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures. The Newborn Screening Laboratory will provide quarterly unsatisfactory specimen collection reports to the program and assist in developing training and educational materials.

Update: The TDH laboratory received a total of 364,212 initial specimens during FY 03. 4,104 or 1.12 % of specimens received were unsatisfactory for testing. 96 technical assistance contacts were made to providers during FY 03. 18,538 educational materials targeted at providers were distributed and included specimen collection guides, collection posters, CDs, newsletters, practitioner guides, and weight conversion charts. This represents a significant decrease from the 122,563 pieces of literature distributed during FY 02, due in part to that during FY 03 many of the educational materials were available only at the program's website. 13 on-site workshops on issues related to newborn screening were held throughout the state. 2 newborn screening exhibits were presented at the Public Health Nursing Conference and the Vital Statistics Conference in FY 03.

Activity 2: Educate parents 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 website, and making an email address available for any questions regarding newborn screening.

Update: 122,563 educational materials about newborn screening benefits targeting parents and health professionals were distributed during FY 03 to both providers and parents. These included brochures on newborn screening new submitter packets, posters and second screen reminder refrigerator magnets. 323,021 web site visits were made during FY03. New website additions include: HIPAA links, PKU Connections Newsletter, Congenital Adrenal Hyperplasia Newsletter, Sickle Cell Disease Guidelines, PKU Medical Foods Pilot Final Report to the Texas Legislature, and English/Spanish printed versions of the Galactosemia Food Card, congenital hypothyroidism, and congenital adrenal hyperplasia brochures. Title V staff targeted mail solicitations on the availability of newborn screening materials to a combined total of 613 hospitals or nursing schools. 65 responses were received and as a result, 37,425 additional brochures, reminder magnets, and collection guides were distributed.

Performance Assessment: During FY 03, continued 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 Texas to again exceed the 95% performance objective, with 95.6% of or 364,212 newborns receiving at least 1 screening.

## b. Current Activities

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures. The Newborn Screening Laboratory will provide monthly unsatisfactory specimen collection reports to the program and assist in developing training and educational materials.

Update: From Sep. 03 through Feb. 04, the TDH laboratory received 185,992 initial specimens. 2,326 or 1.25% of the total received were unsatisfactory for testing. 93 technical assistance contacts were made to providers from Sept. 03-Feb. 04. The increase in the number of contacts from those reported in the same time frame last year is, in part, attributable to the Dec. 03 NBS newsletter that included an order form for materials along with an 800 number. 9,198 educational materials, primarily targeted at providers, have been distributed to hospitals, clinics, laboratories, and midwives including specimen collection guides and posters, CDs, newsletters, practitioner guides and weight conversion charts. In the Dec. 03 issue of the NBS Newsletter, the program actively promoted the availability of newborn screening literature. Over

100 responses were received for information on newborn screening, with 49 specifically requesting and receiving training material on specimen collection.

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

Update: Between Sept. 03 and Feb. 04 a total of 169,479 web site visits were recorded. During the same time frame, over 63,332 educational materials on newborn screening issues targeting parents and health professionals were distributed.

During FY 04, the NBS Program continued the Maternal PKU Project. This project involves program staff contacting the parents of all female patients aged 15 years and over and diagnosed with PKU to alert the parents to the dangers and appropriate treatment during pregnancy. During the first 2 quarters of FY 03 the NBSP mailed 33 packets of information including "The Young Woman with PKU" and "Lets Focus on PKU and Pregnancy" for adolescents with PKU ages 11-15 years old and "The Young Woman with Mild Hyperphe."

The CARES (Congenital Adrenal Hyperplasia Research, Education, and Support) Foundation, Inc. contacted the NBS for assistance in promoting their CARES CAH Picnic held during FY 04 in the Dallas/Tarrant County area. NBS staff mailed 360 invitations to parents of children that were diagnosed through the program with Congenital Adrenal Hyperplasia (CAH). A total of 49 people attended the picnic.

### c. Plan for the Coming Year

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

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

Monitoring: Monthly review of percent increase/decrease in unsatisfactory specimens.

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

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

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

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

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

years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

#### a. Last Year's Accomplishments

This measure was implemented in FY 04. See the current activities section for an update on FY 04 activities related to this measure.

Performance Assessment: As in FY 02, and according to the national CSHCN SLAITS survey, approximately 57% of CSHCN aged 10-19 years whose families partner in decision making at all levels reported satisfaction with services received. Activities related to this measure commenced in FY 04 and are detailed in the next section. FY 05 activities planned to continue progress toward this measure include continuing informal and formal mechanisms for partnering; promoting family networking; and monitoring quality assurance plans and assessment processes employed by contractors to measure progress toward family partnership and satisfaction.

#### b. Current Activities

Activity 1: Continue formal and informal mechanisms for partnering in decision making with families of CSHCN and promoting family networking.

Update: The statewide CSHCN Advisory Committee (CSHCNAC) was abolished by legislative mandate. This year, the CSHCN program has begun to develop other methods to obtain and document family and stakeholder input. Methods include the development and use of improved documentation and tracking of meetings and the issues raised during the meetings by both program and contractor CSHCN staff. Both routinely use this improved tracking to document family/stakeholder concerns, issues, input and recommendations and program staff routinely evaluate the overall family/stakeholder input and its subsequent impact on program operations.

This year, 306 consumers have participated in 45 meetings reported on by CSHCN staff and contractors. Meetings covered a wide range of topics to include Texas' reorganization of health and human service agencies, Medicaid and CHIP rules changes, access for services, the need for respite care, transition issues, permanency planning and the waiting list.

Activity 2: Require and confirm that all service contractors have quality assurance plans and provide technical assistance and training to service contractors so that by FY 05 all the quality assurance plans include ways to measure progress toward the Title V CSHCN national performance measure of family partnership and satisfaction.

Update: Program service contractors are required to assess family participation and satisfaction. CSHCN staff specifically defines family participation and satisfaction requirements for case management, direct service, family-to-family partnership, wellness center, and medically fragile children contractors. While there is no specific stated requirement for community and family resources contractors many contractors assess and report on family participation and satisfaction. Conference calls are held with contractors to assess family input and contractor input, coupled with ongoing technical assistance provided and on-site evaluations conducted as appropriate. Information gathered from contractors will be evaluated and used to generate recommendations for FY 05 contractor requirements and reporting. This year staff conducted 4 conference calls with contractors to discuss the Title V Performance Measures and to begin the discussion and effort on revising quality assurance plans to better reflect these measures. As of the end of Feb. 04, 2 case management contractors have revised QA plans and most of the remaining contractors report beginning the process to revise their QA plans; the Family-to-Family Partnership contractor and 75% of Wellness Center contractors report ongoing completion of family satisfaction surveys and as of May 04, 80% of case

management contractors report ongoing QA activities. Staff provides training and technical assistance to contractors about family partnership and satisfaction.

### c. Plan for the Coming Year

Activity 1: Continue formal and informal mechanisms for partnering in decision making with families of CSHCN and promoting family networking through forums that include, among others, committees and councils having CSHCN family representatives, focus groups, ad hoc groups/task forces, input from case management contacts/activities, etc.

Output Measure: Number of CSHCN consumers attending CSHCN policy and networking related meetings; number of opportunities, to include meetings and forums, in which families of CSHCN were involved and provided input.

Monitoring: Collect data on CSHCN family participation on an ongoing basis and document partnership activities.

Evaluation: Annual review of CSHCN family partnering mechanisms to assess the extent of partnering and consumer involvement in decision-making.

Activity 2: Require and confirm that all service contractors have quality assurance plans and provide technical assistance and training to service contractors so that all quality assurance plans include ways to measure progress toward the Title V CSHCN national performance measure of family partnership and satisfaction.

Output Measure: Number of contractors with quality assurance plans that include ways to measure family partnership and satisfaction; number of contractors who conduct satisfaction surveys; numbers of contractors who do not conduct surveys; number of families responding to surveys; and overall response rate.

Monitoring: Monitoring of quality assurance plans and quality assurance activities.

Evaluation: Documentation that contractor quality assurance plans measure and report progress toward the national performance measure of CSHCN family partnership and satisfaction.

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

### a. Last Year's Accomplishments

This measure was implemented in FY 04. See the current activities section for an update on FY 04 activities related to this measure.

Performance Assessment: In FY 03, and according to the CSHCN SLAITS survey, 58.4% of CSHCN age 1-18 received coordinated, ongoing, comprehensive care within a medical home, achieving the annual performance objective. In FY 04, CSHCN program staff implemented activities related to this measure and those activities are detailed in the next section. During FY 04, in addition to continuing the activities begun in FY 04, CSHCN program staff will also develop a strategic plan for promoting and assisting in the development of medical homes for CSHCN and continue their efforts in facilitating a Medical Home Workgroup to foster inter-organizational work on establishing medical homes.

### b. Current Activities

Activity 1: Inform CSHCN medical providers and families of the principles and practice of providing/obtaining and using a medical home through participation in the Texas Medical Home Training Conference and through dissemination of materials in the CSHCN Program's bulletin,

newsletter, and website.

Update: In 10/03 regional and central CSHCN staff, who also participated in planning the conference, attended the American Academy of Pediatrics sponsored Texas Medical Home Training Conference (TMHTC), "Every Child Deserves a Medical Home." 145 people attended including health care professionals and family members.

In follow-up to the TMHTC, a Medical Home Workgroup (MHWG) was developed with members from the conference and pre-conference, related programs such as Healthy Child Care Texas Grant and State Early Childhood Coordination Planning Grant, other agencies, and individuals concerned about CSHCN. Since 1/04, the MHWG has met monthly with members and have developed their mission and vision statements as initial steps in creating a strategic plan for promoting medical homes in Texas.

In FY 04 the CSHCN Program distributed articles on medical home issues via the Family Newsletter and Provider Bulletins, with between 3,400 and 4,900 issues mailed of each. An article focusing on the medical home concept was highlighted in the 2/04 CSHCN Provider Bulletin and a fact sheet on the medical home was developed for distribution in provider workshops scheduled for the 4th quarter. An article focusing on the benefits of a medical home "What Can a Medical Home Do For You?" was published in the 4/04 family newsletter (accessible at <http://www.tdh.state.tx.us/cshcn/default.htm>. Draft materials were developed for inclusion on the prospective Medical Home section of the website.

Activity 2: Document case management efforts to connect CSHCN with medical homes.

Update: Regional staff provides case management services that include linking CSHCN with medical homes and reporting the number of those contacts. CSHCN staff also drafted a policy for regional staff containing a definition of medical home and specifying that regional staff case management includes linking CSHCN to medical homes as part of individualized case management services. Program contractors, specifically case management and direct service contractors, are required to link CSHCN with medical homes. Contractors develop their own policies and procedures around the client assessment that includes an assessment of the medical home situation and referral needs. Program staff monitors contractor's compliance through review of performance reports and on-site review of policies and procedures.

To date in FY04, regional case management staff made 6,981 contacts with families and providers to link children to a medical home and foster development of medical homes. Of 4,074 children currently on contractor's case management programs, contractors report that 3,837 (94%) are served by a medical home.

### c. Plan for the Coming Year

Activity 1: Inform CSHCN medical providers and families of the principles and practice of providing/obtaining and using a medical home through the TDH-organized Medical Home Work Group and through dissemination of materials, including articles and references, of best practices and education/training opportunities on this topic in the CSHCN Program's provider bulletin, family newsletter, and via the CSHCN website.

Output Measure: Number and type of related activities conducted by CSHCN staff to include meetings attended and number of articles and references provided via bulletins, newsletters and website; number of CSHCN providers, consumers, and agency staff participating in the Medical Home Work Group; development of strategic plan to establish and promote medical homes; and number of others who received materials concerning medical home issues.

Monitoring: Quarterly reporting on TDH-organized Medical Home Work Group meetings convened; number and identification of participants; development of strategic plans; and articles, references, and education/training opportunities promoted.

Evaluation: Assess quantity and type of staff participation in related meetings and the volume

of information produced and disseminated.

Activity 2: Document case management efforts by TDH staff and contractors to connect CSHCN with medical homes.

Output Measure: Policies in place with regional offices and with CSHCN contractors pertaining to client connection to medical homes.

Monitoring: Data from regional case management staff and from service contractors' quarterly reports.

Evaluation: Assess trends in data collected.

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

#### a. Last Year's Accomplishments

This measure was implemented in FY 04. See the current activities section for an update on FY 04 activities related to this measure.

Performance Assessment: During FY 03 and as in FY 02, and according to the national CSHCN SLAITS survey, approximately 52.9 % of families with special health care need aged 0 to 18 reports having adequate private and public insurance to pay for needed services. Specific activities related to this measure commenced in FY 04 and are detailed in the next section. FY 05 activities planned to continue progress on this measure include continuing the activities begun in FY 04 and participating in interagency efforts to identify and alter policies inhibiting CSHCN from obtaining adequate insurance coverage.

#### b. Current Activities

Activity 1: Document payment of insurance premiums for clients on the CSHCN Program to help families maintain private insurance.

Update: As of Apr. 04, 51 clients statewide had received insurance premium assistance paid by the CSHCN program. A total of 60.7% of the payments were paid for CSHCN between the ages of 1 through 14.

Activity 2: Document provision of health care benefits to those eligible for CSHCN services.

Update: As of Apr. 04, 1,449 clients were receiving CSHCN Program health benefits with clients from the Dallas metro area, Houston metro area, and South Texas representing 64% of the total receiving benefits. A total of 76% of those receiving services are between the ages of 6 though 18.

Activity 3: Document the number of CSHCN on the waiting list by age and region who have no other source of insurance.

Update: As of Feb. 04, a total of 75 clients from across the state, with no other source of insurance, were on the CSHCN program's waiting list.

#### c. Plan for the Coming Year

Activity 1: Document payment of insurance premiums for clients on the CSHCN Program to help families maintain private insurance.

Output Measure: Number of CSHCN in by age and region for whom the CSHCN Program pays insurance premiums.

Monitoring: Periodic data collection on schedule.

Evaluation: Assess trends in data collected to include evaluating the increase or decrease in the number of CSHCN families receiving premium payment assistance.

Activity 2: Document provision of health care benefits to those eligible for CSHCN services.

Output Measure: The number of CSHCN by age and region receiving health care benefits through the CSHCN program.

Monitoring: Periodic data collection on schedule.

Evaluation: Assess trends in data collected, to include evaluating increase or decrease in the number of CSHCN receiving health care benefits through the CSHCN program.

Activity 3: Document the number of CSHCN on the waiting list by age and region who have no other source of insurance.

Output Measure: Number of CSHCN by age and region who are on the program's waiting list who have no other source of insurance.

Monitoring: Periodic data collection on schedule.

Evaluation: Assess trends in data collected, to include evaluation fluctuations in the number of CSHCN who are on the CSHCN program waiting with no other sources of insurance.

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

#### a. Last Year's Accomplishments

This measure was implemented in FY 04. See the current activities section for an update on FY 04 activities related to this measure.

Performance Assessment: During FY 03, and as in FY 02, over three-fourths of parents (or 76.9%) with CSHCN surveyed in the CSHCN SLAITS survey, report that community-based service systems are organized so they can use them easily. Activities related to this measure commenced in FY 04 and are detailed in the next section. FY 05 activities planned to continue progress toward this measure include continuing to fund contracts to support community-based service systems' infrastructure organization and coordination, continued participation in state level forums on issues pertaining to CSHCN, and continuing to provide information to stakeholders via the toll-free information and referral line and the program's website.

#### b. Current Activities

Activity 1: Continue to fund contracts to support community-based service systems' infrastructure organization and coordination.

Update: In FY 04, the CSHCN funds 14 CSHCN case management and community/family resource services contractors to support community-based service systems infrastructure organization and infrastructure. As of 5/04, contractors served 7,515 families and had attended

over 632 local/community meetings at area coalitions. Meetings, attended by a wide variety of public and private partners, are information-sharing opportunities to enable contractors to better link families to services appropriate to their needs, to better coordinate services, and to explore ways to improve the local services system. Contractors also participated in hearings related to the upcoming changes to the state health and human services agencies in order to voice concerns and anticipate local level coordination changes. A total of 80% of all CSHCN case management contractors report ongoing QA activities with 2 already submitting revised QA plans reflecting the Title V performance measures.

Activity 2: Continue to publicize and gather/monitor public input and feedback on the program and service delivery via the toll free information and referral line, as well as the CSHCN Program website.

Update: Between 9/03 and 5/04 the information and referral line received a total of 8,170 calls. These calls resulted in 11,024 referrals to contractors and/or other programs or services. In FY 04, the CSHCN website (<http://www.tdh.state.tx.us/cshcn/default.htm>) received an estimated 47,926 hits. A review of the contacts to the web site and calls to the referral line indicate that the majority received regarded how to obtain services, not exclusively CSHCN services. Program staff are planning later in FY 04 to formally collect, review and report on the content of the feedback received. In late FY 04, program staff will meet to assess the input and its effect on program operations.

Activity 3: Continue participation in state-level advisory groups, task forces, committees and similar forums that are working on issues pertaining to CSHCN.

Update: To date in FY 04, Austin-based and regional CSHCN staff attended and reported on 65 meetings covering issues pertaining to CSHCN. CSHCN contractors reported on 8 meetings they attended. Cumulatively, the meetings reported on by CSHCN staff and contractors were attended by 260 parents, families or CSHCN, 622 service providers, 514 agency staff, 210 representing other agencies or individuals, and 245 individuals who could not be classified. The meetings covered a diversity of topics including the continued discussion of the impacts of HB 2292; systems of care assessment; permanency planning; transition issues, permanency planning, community assessment, and cost share programs. CSHCN staff meet through out the year to evaluate the input received at these meetings and to discuss the program impact and response.

### c. Plan for the Coming Year

Activity 1: Continue to fund contracts to support community-based service systems' infrastructure organization and coordination.

Output Measure: Number of contracts funded that support community-based service indicating satisfaction with the program.

Monitoring: Quarterly reporting on contracted activities that address infrastructure organization and coordination and progress on development of contractor quality assurance plans to measure and report on the national performance measures.

Evaluation: Documentation of contractor funding, activities, and quality assurance plans.

Activity 2: Continue to supply critical program-specific and community service information and gather and review public input and feedback on the program and service delivery systems via the toll free CSHCN program service telephone line and number of hits on the CSHCN website.

Output Measure: Number of calls to the toll free CSHCN program service telephone line and number of hits on the CSHCN website.

Monitoring: Review quarterly website and toll free line reports for trends in input/feedback.

Evaluation: Identification of trends in positive and negative feedback from consumers and providers.

Activity 3: Continue participation in state-level advisory groups, task forces, committees and similar forums that are working on issues pertaining to CSHCN.

Output Measure: Number of relevant groups and meetings that include CSHCN Program staff participation; number and type of major issues addressed.

Monitoring: Quarterly reporting of specific roles, responsibilities, activities and outcomes resulting from CSHCN Program staff participation in these efforts.

Evaluation: Documentation of staff participation and identification and assessment of major issues addressed and the impact on program operations.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

#### a. Last Year's Accomplishments

This measure was implemented in FY 04. See the current activities section for an update on FY 04 activities related to this measure.

Performance Assessment: While state representative data are not yet available on this measure, activities commenced in FY 04 to further facilitate progress toward this measure and those activities are detailed in the next section. FY 05 planned activities relating to this measure include providing information and links on the CSHCN program website, providing transition or transition-related information and education in CSHCN publications and continued staff participating on inter-organizational workgroups addressing transition to adult services.

#### b. Current Activities

Activity 1: Participate in the Leadership Education in Adolescent Health (LEAH) Advisory Board and document CSHCN staff roles, responsibilities, activities and outcomes.

Update: In Nov. 03, CSHCN Program staff participated in LEAH's annual transition conference, "Chronic Illness: How to Transition from Child-oriented to Adult-oriented Care." Feedback from the meeting was helpful to program staff in identifying some concerns that CSHCN providers have in responding to a question on the Physician Assessment Form. Also, in partnership with the LEAH efforts, the CSHCN Program is developing a section of the CSHCN website focused on transition issues. Another meeting of the LEAH Advisory Committee is planned for 7/04.

Activity 2: Provide articles and references on best practices and education/training tools on transition for CSHCN for families of and/or providers via the Family Newsletter, Provider Bulletin, CSHCN website, and as possible through mail outs with various partners (e.g. advocacy groups, professional organizations, CHIP/Medicaid providers, etc.).

Update: On an ongoing basis, the CSHCN Program distributes articles on transition issues via the Program's Family Newsletter and Provider Bulletins. The Provider Bulletin is routinely distributed to over 3,400 providers while the Family Newsletter has a readership of over 4,800. From 12/03 through 2/04, articles in the Provider Bulletin included "The Importance of Self-Determination" and "Transition Part 1 -- What is Transition and Why Is It Important?" Articles submitted for printing in the family newsletter included 1 on the Title V performance measures as well as 1 on deinstitutionalization. During FY 04, a transition work group was convened to assist with the development of transition resources for CSHCN, their families, providers, and CSHCN and case management staff. Their planned projects included developing a training

module on transition. However, the workgroup's efforts have been temporarily halted due to staff changes and reorganization efforts.

### c. Plan for the Coming Year

Activity 1: Participate in the Leadership Education in Adolescent Health (LEAH) Advisory Board and document CSHCN staff roles, responsibilities, activities and outcomes.

Output Measure: Number of meetings that include CSHCN Program staff participation; number and types of activities addressed and/or planned.

Monitoring: Quarterly reporting of specific roles, responsibilities, and activities of the CSHCN Program staff in these efforts.

Evaluation: Documentation of staff participation and types of activities addressed and planned; identification and assessment of issues address and the impact on program operations.

Activity 2: Provide articles and references on best practices and education/training tools on transition for CSHCN for families of and/or providers via the Family Newsletter, Provider Bulletin, CSHCN website, and as possible through mail outs with various partners (e.g. advocacy groups, professional organizations, CHIP/Medicaid providers, etc.).

Output Measure: Number of articles, references, education/training tools provided; number of publications information printed in; number of mail outs participating in.

Monitoring: Quarterly tracking and documentation of these efforts.

Evaluation: Volume of information produced and disseminated.

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

### a. Last Year's Accomplishments

Activity 1: Renew the contract with Texas A&M Extension Service to conduct parent education train-the-trainer workshops for professionals, daycare staff, and community leaders.

Update: The Texas Cooperative Extension organized and conducted 8 Parent Education Workshops for 488 community professionals representing a variety of partners (i.e. schools, Head Starts, state agencies in 7 different locations through out Texas. Each workshop covered the importance of immunizations, child health and safety, and nutrition as well as several other child-focused topics. Each workshop participant received a copy of the curriculum containing materials necessary to conduct a series of parent education classes with parents of children birth to age 5.

Activity 2: In order to improve immunization rates in Texas, develop recommendations to be included in the comprehensive state plan and presented to the TDH Board of Health

Update: The first phase of the Immunization Improvement project included a business review of the Immunization Division by the TDH Business Improvement Office (BIO) that was completed in 6/03. The BIO in its 7/03 final report identified 14 key issues and made 36 recommendations for improvement in areas such as staff and systems support, Immunization Registry support, resource allocation, quality assurance, communications and training, and implementation of the new Pharmacy Inventory Control System (PICS). During 7/03, TDH unveiled an action plan to increase childhood immunization rates. The 5 points plan includes a "Back to School" campaign urging immunization of school children and their siblings; enacts emergency rules to require 5 Diphtheria-tetanus-acellular pertussis immunizations; rolls out a new bilingual multimedia public awareness campaign; expedites new recommendations to improve the

state's immunization program; and implements new legislation supporting immunizations. Implementation plans were developed for the 5-point plan and recent legislative mandates include establishing a continuous, statewide education program for parents and physicians, establishing methods to streamline enrollment and reporting for the Vaccines for Children program, improving the immunization registry, and establishing methods to address the new vaccination exemption statute.

Activity 3: 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.

Update: In FY 02 and early FY 03, the instrument used by TDH's Quality Assurance Division monitoring staff was revised and the question related to this performance measure was removed. Therefore, no data was collected for this performance measure in FY 03.

A performance assessment for this section is attached.

#### b. Current Activities

Activity 1: As a Health Child Care America grantee, the Child Wellness Division will develop a plan with the TDH Immunization Division to promote timely, age-appropriate immunizations through the use of the IMMTRAC system by child care centers.

Update: The purpose of the Healthy Child Care America grant is to train qualified individuals to be child care health consultants (CHC). In this role the CHC's consult with and train both individual and groups of child care providers on health and safety issues. Jan. 04 training participants learned about Texas' Immunization Registry (IMMTRAC) and the benefits of their participation in the system and how to get child care providers enrolled in IMMTRAC. In Feb. 04, Title V staff met with the IMMTRAC leadership to learn about the program and to discuss how childcare providers could access the programs and the benefits of participating.

Discussion also focused on how the Health Child Care Texas (HCCT) initiative could reach child care providers to encourage their participation in the program. IMMTRAC staff attended the Mar. 04 HCCT Task Force meeting and gave an overview of IMMTRAC system history including legislation, public and provider reaction, and how the system actually works. Several new physicians attended and were interested in learning about the benefits of the system and how both they and childcare providers could use the system. IMMTRAC staff also wrote an article submitted to the Texas Association for the Education of Young Children's for their Summer 04 newsletter. Texas Title V and IMMTRAC staff will begin tracking statistics to determine if there is an increase in child care providers signing up to access information in the IMMTRAC system.

#### c. Plan for the Coming Year

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

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

Monitoring: Track the number and type of partnership activities.

Evaluation: Assess the effectiveness of collaborative efforts among partners. Assess any change in statewide immunizations rates.

## a. Last Year's Accomplishments

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

Update: In FY 03, 29,635 teens, as compared to 32,602 in FY 02, aged 15-17, were enrolled in family planning services (FPS) funded by Titles V, X, XIX and XX. Fewer dollars were allocated for FPS in FY 03, which, in part, explains the decrease between FY 02 and 03 reports.

Activity 2: Develop and distribute resource materials to raise public awareness of teen pregnancy among Hispanic and African American female teenagers aged 13-17 years.

Update: In FY 03, the mechanism for distributing resource materials to raise public awareness of teen pregnancy shifted from hard copy distribution to web-based information sharing. During FY 03, information was made available to family planning contractors via the program's secure website. FY 04 plans include exploring options for making the resources available to the general public and the addition of a counter to measure the number of hits to the website.

Activity 3: Provide funding for community-based abstinence projects for adolescents and teenagers.

Update: During FY 03, the Abstinence Education Program (AEP) served a total of 402,243 clients and funded a total of 33 contractors located in 10 of TDH's 11 PHRs. The number of clients served by the AEP in FY 03 increased by 9,442 clients over FY 02 reported figures. This slight increase may be, in part, attributed to an increase of 2, for a total of 33, AEP funded contractors throughout Texas. All regions, except for PHR 5 (East Texas) and PHR 10 (Midland), have at least 1 AEP contractor.

Activity 4: Provide funding to Title V contractors for population-based activities to reduce and prevent pregnancy among adolescents and teenagers.

Update: FY 03 is a continuation year for funding to Title V contractors for this activity. In FY 03, 97 agencies provided services to reduce and prevent pregnancy in adolescents and teenagers. These agencies have a total of 387 clinics associated with their agencies. A total of 10 of 25 Title V funded population-based contracts dealt with issues related to teen pregnancy. Contractors educated teenagers on self-esteem, human sexuality, and abstinence until marriage, contraceptives, how to make responsible choices, etc. Each contractor is evaluating their efforts differently and additional information on the evaluation results will be included in future annual reports.

Performance Assessment: Based on reported data over the last 4 years, Texas data reflects that Texas has maintained a birth rate below the annual performance objective of 50 births per 1,000 for teenagers aged 15-17 years. However, it has increased slightly for the second straight year from 38.9 in FY 02 to 40.6 in FY 03. TDH continues to provide family planning services, as well as resources to assist contractors with their educational efforts. Other state and community-level efforts continue.

## b. Current Activities

Activity 1: Develop and provide via the Internet, resource materials to raise public awareness of teen pregnancy in Texas, including teen pregnancy rates among Hispanic and African American female teenagers less than 17 years.

Update: TDH Title V staff maintains a provider and public web-site (<http://www.tdh.state.tx.us/women/teenpreg.html>) providing information about teen pregnancy. During FY 04, information found and updated on this page includes statistics and data, best

practices, and information on cost, outcomes, and social consequences of teen pregnancy. In FY 04, a new 2001 Teen Pregnancy and Birth Fact sheet was updated and added to the site in preparation for May's Teen Pregnancy Prevention month. The public page averages approximately 20-35 hits per month while the Teen Pregnancy Prevention Packet Page on the provider area of the website, averages between 15 and 18 hits per month.

In the first quarter of FY 04 an article entitled "Fourteen and Younger," was placed on the Provider Section of the Teen Pregnancy Prevention Page. The article covered a new report published by the Campaign to Prevent Teen Pregnancy on adolescent sexual behavior and includes several links to other sites containing information about teen pregnancy. The Spring 04 issue of Texas Talk was dedicated entirely to the topic of teen pregnancy.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.

Update: The Abstinence Education Program (AEP) has 42 contractors in FY 04, with at least 1 contractor in each TDH public health region. To date in FY 04, the AEP has served 255,797 clients.

Activity 3: Provide funding to Title V contractors for population-based activities and family planning services to reduce and prevent pregnancy among adolescents and teenagers.

Update: Currently Texas has 95 contractors providing family planning services funded by Titles V, X, and XX. Title V funds, in whole or in part, 60 of these contractors. All family planning contractors, to some degree, conduct teen pregnancy prevention activities that include education sessions on reproductive health, family involvement, and wellness issues such as physical activity and appropriate nutrition, parenting for teen parents, prevention of subsequent teen pregnancies, outreach, and services to teens.

Activity 4: Funding awarded to Title XX contractors for family planning activities to reduce and prevent pregnancy among adolescents and teenagers.

Update: Currently Texas has 95 contractors providing family planning services funded by Titles V, X, and XX. Title XX funds, in whole or in part, 50 of these contractors. All family planning contractors, to some degree, conduct teen pregnancy prevention activities that include education sessions, outreach, and services to teens.

### c. Plan for the Coming Year

Activity 1: Develop and provide via the Internet, resource materials to raise public awareness of teen pregnancy in Texas, including teen pregnancy rates among Hispanic and African American female teenagers less than 17 years.

Output Measure: Number and types of materials uploaded to the web site; number of hits to the Teen Pregnancy Prevention Page of the Women's Health Website.

Monitoring: Ensure and monitor development and provision of resource materials; track the number of hits to the web site.

Evaluation: Assess the usefulness of web-based teen pregnancy prevention materials via an annual poll of various stakeholders. Evaluate changes in teen pregnancy rate in Texas.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.

Output Measure: Number of unduplicated clients served, including teens/children, parents, and health providers that are provided with abstinence education information by age, ethnicity, and service delivery area served for unduplicated clients. Number and type of contacts made or received from community based organizations regarding abstinence education.

Monitoring: Review abstinence contractor reports of the number of unduplicated clients and the areas served on a monthly basis. Provide technical assistance to improve contractor performance.

Evaluation: Determine contractor goals for the projected number of clients to be served, and review contractor performance from monthly reports.

Activity 3: Provide funding to Title V contractors for population-based activities and family planning services and to Title XX contractors for family planning activities to reduce and prevent pregnancy among adolescents and teenagers.

Output Measure: Number of contractors involved in teen pregnancy prevention activities; number of contractors providing family planning services.

Monitoring: Review TDH contractor progress reports on a quarterly basis.

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

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

#### a. Last Year's Accomplishments

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

Update: During FY 03, of the 3,572 third graders examined statewide, 1,550 or 43% had sealants on at least 1 permanent tooth. The FY 03 total was approximately half of those examined in FY 02 (7,072) due to reduced staffing resources available for this activity. Information specific to molar teeth is currently not collected.

Activity 2: Continue statewide promotion of sealant benefits by distributing educational materials for parents and teaching oral health curriculum to children in selected Texas schools, particularly schools in Regions 6 & 11.

Update: Educational sealant brochures were given to each child receiving sealants. A total of 52,049 educational materials relative to oral health were also distributed to parents and educators.

Performance Assessment: Texas data reveal that the FY 03 performance objective of 21% for 3rd grade children receiving sealants was exceeded, with 43.4%, or 1,550 children receiving sealants, representing an almost 5% increase from FY 02 reported data. The reader should note that the data are limited, because the denominator includes only children in Texas' free lunch program, and may not be generalized to the larger population. Overall fewer children were screened during FY 03 than in FY 02 due to resource limitations, but the percentage of those screened who had sealants has increased. This increase, may in part, be attributable to increased usage of sealants and enhanced education and outreach in the Medicaid population, frequent recipients of Texas' free school lunch program.

## b. Current Activities

Activity 1: Continue providing dental sealants to Texas' 3rd grade population.

Update: To date in FY 04, regional-based dental staff has provided dental sealants to 4,875 third graders statewide. Data specific to permanent molar teeth is not collected.

## c. Plan for the Coming Year

Activity 1: Continue providing dental sealants to Texas' 3rd grade population.

Output Measure: Number of third graders who received dental sealants.

Monitoring: Track progress of the data collection and analysis.

Evaluation: Recognizing limitations of translating results from a selected population to the general population, assess any changes in the percentage of third graders receiving dental sealants.

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

## a. Last Year's Accomplishments

Activity 1: Provide traffic-safety presentations to children ages 0-8 regarding bicycle and car seat safety.

Update: Since 9/02, the Safe Riders Traffic Safety Program provided 65 child passenger safety presentations in various parts of the state to a total of 1,341 children/adults. Monthly calendars of upcoming events are sent statewide to Texas Department of Transportation's Traffic Safety Specialists as well as their Austin-based staff.

Children are asked questions before and after the presentation to determine what they learned and understand, while adults are tested in writing. The results of these pre- and post presentation tests show that children enjoy sharing their enhanced knowledge and parents report enhanced understandability and learning.

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

Update: A total of 12,760 safety seats for low-income families have been ordered and distributed to the 113 safety seat distribution programs. The FY 03 total number of seats purchased was 7,531 less than those purchased in FY 02 due to decreased funding availability. While the seats were distributed statewide, 1,696 of the total number of seats were targeted for distribution in both 9 urban areas and the Texas/Mexico border distribution sites having the lowest seat utilization rates with a documented need for safety seats.

In FY 03, a total of 221 people affiliated with the seat distribution sites were trained by TDH staff trained as certified Child Safety Seat Technicians and 8 on-site technical assistance visits to the sites were made.

Data from the Texas Transportation Institute (TTI) states that child restraint usage for FY 03 was 73.3%, as compared to usage of 71.7% in FY 02. Of the 73.3% restrained, 30.4% were correctly restrained. This increase, in part, is due to the safety seat distribution program and

educational opportunities for both children and adults.

Performance Assessment: In FY 03, there were 263 reported deaths among children aged 14 years and younger caused by motor vehicle crashes, a fatality rate of 5.6 per 100,000 children, slightly higher than then the 5.5 per 100,000 objective. Texas will continue efforts that should positively impact this measure. Those measures include providing education and child safety seats throughout the state.

## b. Current Activities

Activity 1: Provide traffic-seat safety presentations to children ages 0-8 regarding car seat safety.

Update: Since Sept. 03, the Safe Riders Traffic Safety Program has provided 69 child passenger safety (CPS) presentations to a total of 2,951 adults and children. A total of 26 presentations were given directly to 1,437 children ages 8 and under in elementary schools. The remaining presentations targeted parents, mom's clubs, teen parent classes, and parent classes at Babies R Us.

The presentations include information about seat belts and child safety seats and vary from 45 minutes to 2 hours, depending on the targeted age group. Presentations for children are age appropriate and interactive and include information on the consequences of not "buckling up" and children not being secured in safety seats properly.

Children are asked questions before and after the presentation to determine what they learned and understand. Children always enjoy sharing their knowledge. Adults are questioned after the presentation to determine if they understand and have learned the presented information.

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

Update: During FY 04, safety seats were distributed from May-June through a statewide distribution program. A total of 101 applications were submitted from organization across Texas with the capacity and desire to provide education for and seats to low-income families. A total of 95 applicants were selected to take part in the FY 04 distribution program. Each organization received safety seats to share with their low-income families. 100% of the organizations attended a mandatory 4-hour safety seat training in order to be able to issue seats to their families. The 95 organizations received and will distribute 11,398 safety seats.

## c. Plan for the Coming Year

Activity 1: Provide child passenger safety presentations to children ages 0-8 regarding car seat safety.

Output Measure: Number of presentations conducted statewide; number of children/adults attending each presentation.

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

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

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

age 8.

Output Measure: Number of seats distributed statewide.

Monitoring: Track development and progress of distribution program.

Evaluation: Assess the effectiveness of the project by reviewing data from the Texas Transportation Institute on statewide child restraint usage in comparable areas.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

#### a. Last Year's Accomplishments

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

Update: During FY 03, the WIC breastfeeding rate increased from 61.6% in 9/02 to 62.6% in 8/03, representing a minimal increase from the FY 02 rate of 59.1%.

Activity 2: Improve community access to educational and support resources to promote breastfeeding by providing multiple venues such as maintaining the breastfeeding website and funding community breastfeeding education initiatives, particularly among African American families.

Update: In FY 03 there were 276 peer counselors working in WIC clinics. In FY 03, TDH and Title V staff trained a total of 255 peer counselors including WIC clerks, nutritionists, nurses, and hospital nurses, among others. 114,510 hits were recorded on the breastfeeding promotion website, representing an increase of 17,509 hits to the site from FY 02. This increase in number of hits may be attributable to informal publicity about the site, the reputation of Texas' breastfeeding promotion efforts, and improved features of the website. The 5th Annual Breastfeeding Summit was held in San Antonio. High profile breastfeeding and health care professionals and speakers gave presentations on topics ranging from the impact of ankyloglossia on breastfeeding to birthing a breastfed baby. 325 individuals attended the summit and included nurses, LVNS, physicians, physician assistants, registered dietitians and others.

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

Update: In FY 03, 8 hospitals have applied and been reviewed for accreditation, and 5 new hospitals and/or birthing centers accredited. Three applications that were not initially accredited were reviewed to identify reasons for denial and appropriate follow-up undertaken to remedy the deficiencies.

Activity 4: Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

Update: There is currently no way to track the number of professionals recommending breastfeeding as the health care provider survey is no longer distributed due to funding issues and a focus on other program priorities. Health care provider packets are no longer being distributed. All training requests have been met. In FY 03, there were 10 Lactation Management, and 10 Lactation Counseling and Problem Solving workshops, and 28 Mini-Basic trainings conducted with 1,756 participants completing training. Each training relates to the promotion and management of breastfeeding.

A performance assessment for this section is attached.

## b. Current Activities

Activity 1: Monitor breastfeeding rates of mothers using available data from Ross Labs, WIC, and PRAMS.

Update: To date in FY 04, WIC reports that 67.3% of WIC mothers are breastfeeding at hospital discharge. WIC also reports that as of April 04, 63% of all WIC infants were breastfed at some point during infancy and that approximately 47% of infants whose mothers were participants in the program during pregnancy initiated breastfeeding at or before the time of the infant's certification of eligibility. FY 04 data from Ross Labs and PRAMS is currently not available.

Activity 2: Improve community access to education and support resources to promote breastfeeding by providing multiple venues such as maintaining the breastfeeding website and funding community breastfeeding education initiatives, particularly among African American families.

Update: The number of WIC peer counselors is not available on a quarterly basis. Local WIC agencies are surveyed once a year to obtain this information, FY 04 data will be available in September 04. Peer Counselor Train-the-Trainer training sessions continue. As of June 04, 20 train-the-trainers attended the training sessions. The Texas Breastfeeding Initiative Website remains a valuable and often used resource for information promoting breastfeeding. To date in FY 04, a total of 47,128 hits have been recorded on the breastfeeding promotion website.

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

Update: During FY 04, 35 letters encouraging hospitals to apply for the program were sent to hospitals regarding accreditation, 7 hospitals applied and 5 new hospitals and/or birthing centers accredited. Program staff continues to provide training and technical assistance via phone, email, and faxes. Development of a FAQ document relative to the Texas Tens Steps and Baby Friendly Hospital Initiative is under discussion.

During FY 04, 35 Ten Step designated hospitals received a letter and questionnaire about their participation in the program. A total of 22 hospitals have responded indicating that they continue to follow the Ten Step Hospital Program. Program staff is evaluating uses of this information.

Activity 4: Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

Update: During the first part of FY 04, a total of 1,061 participants attended 40 trainings focused on breastfeeding and lactation management and the peer-counselor training program. Participants included an ethnically diverse representation of nurses, physicians/physician assistants, dietitians and other health professionals.

## c. Plan for the Coming Year

Activity 1: Monitor breastfeeding rates of mothers using available data from Ross Labs, WIC, and PRAMS.

Output Measure: Percent of mothers breastfeeding at hospital discharge.  
Monitoring: Review WIC, Ross Labs and PRAMS data on a quarterly basis  
Evaluation: Analyze available data to identify the characteristics of breastfeeding mothers and non-breastfeeding mothers at hospital discharge.

Activity 2: Improve community access to education and support resources to promote breastfeeding by providing multiple venues such as maintaining the breastfeeding website and funding community breastfeeding education initiatives, particularly among African American families.

Output Measure: Number of WIC breastfeeding peer counselors; number of WIC and non-WIC participants attending the train-the-trainer Peer Counselor program training by race/ethnicity; number of hits to the breastfeeding website.

Monitoring: Review quarterly progress reports from website; review training participants' evaluation forms.

Evaluation: Evaluate the use of the different types of resources developed and other specific types of requests for information and support by having training session participants complete evaluations and other ad hoc measures such as an annual survey to WIC local agencies, Title V contractors, health care providers, and hospitals. Evaluate the effectiveness of the training based on an analysis of the annual survey data.

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

Output Measure: Number of packets sent to hospitals requesting accreditation; number of new hospitals and birthing centers accredited.

Monitoring: Track progress in providing training and technical assistance as requested.

Evaluation: Determine the number of hospitals and birthing centers that applied but were denied accreditation and follow-up to identify reasons.

Activity 4: Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

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

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

Evaluation: Determine if there was an increase in percent of women breastfeeding at hospital discharge.

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

#### a. Last Year's Accomplishments

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

Updates: On a weekly basis, Texas birthing facilities covered by the newborn hearing screening mandate electronically transmit to the TDH contractor the records of all babies screened. The TDH contractor tabulates the results on a monthly basis. Birthing facilities are

required by Texas law to be certified by TDH and meet specific performance standards. Facilities are noted as being out of compliance if their facility is below any of the standards for 2 of the 3 months in a quarter. At FY 03 end, 194 birthing facilities reported data to TDH on a weekly basis and reported that 97.79% of newborns were being screened.

Due to an intensive effort by the program's contractor in transitioning non-compliant facilities to compliant or to provisional certification by FY end 100% of facilities were in compliance with program requirements.

Performance Assessment: In FY 03, 309,701 screens were conducted, representing 82.4% of births, a minimal decrease from the 84.3% screening in FY 02. With the passage of mandatory testing in FY 00, the percentage has steadily increased but there is still room for improvement in achieving the 92% target objective. Not all hospitals in Texas are required to report screening rates. For those for which reporting is mandatory, or for those that voluntarily choose to report, screening rates exceed 98%. Program activities for FY 04 include ongoing technical assistance and migration of reporting system to a web-based system that should enhance reporting and compliance.

#### b. Current Activities

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

Update: As of May 04, 98.9% of newborns are screened for hearing before their hospital discharge. Weekly, 194 Texas birthing facilities electronically transmit to TDH's contractor the records of all babies screened as required by state mandate. Birthing facilities are also required by mandate to be certified by TDH and to meet specific performance standards. Facilities are considered "out of compliance" if their newborn hearing screening program (NBHS) is below any standard(s) for 2 of the 3 months in a quarter. From Mar. 04 through May 04, 3 birthing facilities were out of compliance with standards. While a facility may be non-compliant for a point in time during the quarter, at quarter end no program remains non-compliant due to remedial action/technical assistance taken by the facility, the contractor, and/or the NBHS Program.

#### c. Plan for the Coming Year

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

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

Monitoring: Document the results of monitoring through monthly reports generated by electronic monitoring system developed for this project.

Evaluation: Assess the level of compliance with certification criteria.

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

#### a. Last Year's Accomplishments

Activity 1: 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.

Update: Title V staff work closely with the Research and Public Health Assessment Division and the Texas Health Steps (EPSDT) program to monitor the ratio of Medicaid child recipients receiving Medicaid services. Analyses of data are done on an annual basis at the time of the grant renewal. According to FY 03 provisional data 1,098,882 or 60% of the percent of Medicaid-eligible children (1,831,982) received a service paid by the Medicaid Program. This increase from the 02 reported percentage of 55.4% may in part be attributable to enhanced outreach and informing to all newly certified Medicaid eligible families with children.

#### b. Current Activities

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

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

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

Update: All Title V contractors actively screen all clients at Title V funded clinics for potential CHIP and Medicaid determination and make referrals as appropriate.

#### c. Plan for the Coming Year

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

Output Measure: Percent of children without health insurance.

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

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.

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

Output Measure: Percentage of children without health insurance identified by Title V contractors.

and referred to CHIP and other state-funded insurance programs.

Monitoring: Follow up on each referral.

Evaluation: Assess the number of children without health insurance who are identified by Title V contractors and referred to CHIP and other state-funded insurance programs.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

#### a. Last Year's Accomplishments

Activity 1: 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.

Update: Title V staff work closely with the Research and Public Health Assessment Division and the Texas Health Steps (EPSDT) program to monitor the ratio of Medicaid child recipients receiving Medicaid services. Analyses of data are done on an annual basis at the time of the grant renewal.

Performance Assessment: In FY 03, Texas exceeded the 53% performance objective for this measure with approximately 60% of children or 1,098,882 children, potentially eligible for Medicaid receiving services paid for by Medicaid. This may be, in part, attributable to mandated enhanced outreach and informing efforts to the enrolled population.

#### b. Current Activities

Activity 1: 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.

Update: Title V staff work closely with the Research and Public Health Assessment Division and the Texas Health Steps (EPSDT) Program to monitor the ratio of Medicaid Child recipients receiving Medicaid services. Analyses are done on an annual basis at the time of grant renewal.

#### c. Plan for the Coming Year

Activity 1: 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.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

#### a. Last Year's Accomplishments

Activity 1: Continue to assess the level and type of interventions needed for each target 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.

Update: During FY 03, the Title V Perinatal Health Coordinator participated in a Ft. Worth forum to address infant mortality and has remained involved as a technical advisor. In FY 03, Title V staff worked with Region VI DHHS and Healthy Start staffs to develop ways to reduce LBW and prematurity. TDH staff participation included meeting with THSA members to network and share information, provide data, serve on a prematurity conference planning committees and attend conferences. Title V staff met routinely with the March of Dimes to plan and implement their 5-year focus on LBW and prematurity.

Activity 2: Develop and implement a state strategic plan to address barriers to reduce the prevention of perinatal HIV transmission.

Update: Meetings between women's health and HIV/STD staff to evaluate progress toward the FY 02 plan continued into FY 03. Data profiles regarding HIV in women, infants and children

were developed for the state and for each TDH PHR and have been shared with the PHRs for use in strategic planning processes. The profiles are available at the TDH website (<http://www.tdh.state.tx.us/hivstd/stats/default.htm>). AMCHP invited the TDH Perinatal Coordinator to speak on the project during the FY 03 Perinatal HIV Transmission Action Learning Lab. In late FY 03, committee members that developed the strategic plan gathered information to update the full committee on plan activities. Title V staff is preparing information in order to develop an annual data report for internal and external stakeholders.

Activity 3: Devise a plan to address the role of perinatal HIV transmission in the high rate of black perinatal mortality.

Update: 2 meetings with consumers and health care providers on Perinatal HIV Transmission occurred in Lufkin and Harris County. Due to lack of funding the social marketing campaign was not implemented in FY 03, however implementation is planned should resources become available.

Activity 4: Provide support to implement the Pregnancy Risk Assessment Monitoring System.

Update: Presentations on PRAMS were given to internal and external stakeholders that included the THSA, the Perinatal Systems Workgroup and the Women's Health Network. In addition, the PRAMS steering committee met in 7/03 where members were oriented on the committee's purpose and reviewed and rated the proposed questions for the next version of the PRAMS questionnaire. Information on each batch of PRAMS questionnaires that are mailed out each month is collected and the questionnaire response rate is approximately 65%. Title V staff continued efforts to improve the PRAMS response rate and to meet CDC goals for representative sample response rates.

A performance assessment for this section is attached.

## b. Current Activities

Activity 1: Continue to assess the level and type of interventions needed for each target geographic area and related sub-populations at risk (e.g., African American women of childbearing age), and provide regional staff and health care providers with data and information on strategies to reduce the occurrence of very low birth weight live births. Provide data and information on the Perinatal Health website.

Update: The Perinatal Health Program Coordinator is in the process of finalizing data reports for each public health region that include information on very low birth weight births (VLBW) for distribution to PHRs and strategies to prevent VLBS. The regions will be able to present this data to local providers and use it for strategic planning at the local level. The Perinatal Health website is scheduled to go online later in FY 04.

Activity 2: Provide ongoing support to continue implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS).

Update: To date in FY 04 there have been PRAMS presentations to the TDH community, the Texas Birth Defects Research Symposium, and the PRAMS Advisory Committee to update participants on PRAMS implementation in Texas. Response rates to batches of distributed questionnaires average around 60%.

Activity 3: Provide ongoing support to the March of Dimes (MOD) 5-year Prematurity Campaign.

Update: Throughout FY 04, Title V staff has participated in both conference calls and campaign

planning meetings related to the MOD 5-year Prematurity Campaign. Title V staff also participated in the Preemie Posse Kick-off event in Nov. 03 and in a program services meeting. The Preemie Posse is a program that arranges for parents of preemie babies to share their knowledge and experiences with new parents of preemies in an effort to help them through the difficulty of parenting a preemie newborn. The program services meeting included an update on the Prematurity Campaign and a funding meeting. The MOD funded 16 proposals that will work directly or indirectly to reduce the incidence of prematurity in Texas. The funded entities will work through a variety of means that include increasing opportunities for prenatal care, setting up incentive programs for entering and complying with prenatal care, using promotoras to work with high-risk pregnant women, and developing and distributing health promotion and education materials. Title V staff also assisted with planning for the Austin Prematurity Summit held in May 04. The summit was designed as a call to action for Central Texas community leaders and to encourage the 75 attending leaders to participate in the prematurity effort in some capacity whether it be volunteering, donating funds, and/or participating in MOD educational programs. State HHS leaders, business leaders, and a local MOD ambassador family made presentations. During FY 04, there have been no MOD data requests.

### c. Plan for the Coming Year

Activity 1: Continue to assess the level and type of interventions needed for each target geographic area and related sub-populations at risk (e.g., African American women of childbearing age), and provide regional staff and health care providers with data and information on strategies to reduce the occurrence of very low birth weight live births. Work with regions with documented higher prevalence of very low birth weights to implement interventions targeted at reducing very low birth weight. Provide data and information on the Perinatal Health website.

Output Measure: Number of areas with very low birth weights identified; reports that include data presented to regions and local health departments about very low birth weight births at the local level; information and/or training provided on strategies to reduce very low and low birth weights; development and modifications to regional activities in targeted prevalence area to reduce very low and low birth weight births; number of hits to the Perinatal Health website. Monitoring: Document dissemination of data and other information to regional and/or local providers located in geographic areas with high percentages of VLBW. Evaluation: Analyze and profile geographic areas and targeted regional areas with a high incidence of very low birth weight births before and after the implementation of the strategies.

Activity 2: Provide ongoing support to continue implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS); to improve overall PRAMS response rate, and to share and/or use PRAMS data, as appropriate.

Output Measure: Number of presentations made to providers and stakeholders on PRAMS; the number of providers and stakeholders participating in PRAMS activities; number of PRAMS respondents by batch; PRAMS annual response rate, and number of requests for PRAMS related data.

Monitoring: Track development and implementation schedule for PRAMS activities; document minutes of meetings with program and PRAMS staff.

Evaluation: Assess the response rate on an annual basis and assess and evaluate the uses of existing PRAMS data.

Activity 3: Work closely with the March of Dimes 5-year Prematurity Campaign.

Output Measure: Number of campaign planning meetings participated in; number of presentations made to providers and stakeholders on prematurity, low birth weight and very low

birth weight; number of and type of state program services committee meetings participated in; number of March of Dimes data requests filled.

Monitoring: Document minutes of meetings and conference calls with March of Dimes; document agendas of presentations; document filling of data requests.

Evaluation: Assess the prematurity and very low birth weight rates on an annual basis.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

#### a. Last Year's Accomplishments

Activity 1: Collaborate with the Adolescent Health Program to provide Mental Health C.P.R. resources to Texas Agricultural Extension agents in 80 counties through a loaner program at the Texas Agricultural Extension offices.

Update: In 8/03, TDH permitted the Texas A&E Extension Program to reproduce the Mental Health CPR curriculum. The material was distributed to 88 Texas A&M Agricultural Extension agents. The Mental Health CPR training tool is a basic manual and training materials for intervening with persons at risk for self-harm.

Activity 2: In order to provide a comprehensive approach to suicide prevention in Texas, a state plan with 5 major recommendations has been developed and sent to the House Committee on Human Services Interim committee. The plan will be shared with stakeholders and the legislature, and used as the basis for obtaining implementation funding.

Update: The Suicide Prevention Steering Committee met in 8/03. 7 community forums were held across the state to facilitate creation of a comprehensive, coordinated and statewide plan based on the Surgeon General's National Strategy for Suicide Prevention (SGNSSP). The committee agreed to revise the state plan based on feedback from the community forums. After reviewing the committee's mission statement, the committee determined that the mission of the steering committee had been completed and efforts to support future legislation would be led by a newly formed Suicide Prevention Network, designed to promote suicide prevention in Texas and advance the state suicide prevention plan based on the SGNSSP. Overall accomplishments of the committee were that they developed the state plan and garnered support for legislative efforts in the arena of suicide prevention. Overall goals of the plan included, among others, promoting awareness that suicide is a public health problem that is preventable; developing broad based support for suicide prevention; developing and implementing strategies to reduce the stigma associated with being a mental health , substance abuse and suicide prevention services customer; and improving reporting and portrayals of suicide behavior, mental illness and substance abuse in the entertainment and news media. TDH staff will work with the new committee and has been asked to participate in a national conference on implementing the SGNSSP.

Performance Assessment: In FY 03, Texas' rate of suicide death among youths aged 15 through 19 continued to decline to 8.2 per 100,000, a moderate decline from the 9.0 reported in FY 02. While recent efforts at mandating activity in this area failed, grassroots efforts continue to positively impact the issue of adolescent suicide. Several combined efforts as detailed in both of the next sections, along with statewide efforts, are scheduled for implementation in late FY 04 and 05.

#### b. Current Activities

Activity 1: In the continued effort to create statewide suicide prevention plan; work with key stakeholders in enlisting broad base support through a grassroots campaign throughout the state.

Update: TDH has long had an involvement and commitment to suicide epidemiology and prevention activities. In 11/03, TDH senior management representatives met with TDH's Commissioner to discuss TDH's role in the implementation of the State Suicide Prevention Plan (SSPP). Management agreed to reassess participation in the state plan after implementation of the bill reorganizing state health and human services agencies. This delay may offer a more effective and efficient allocation of needed resources through better coordination with mental health expertise and resources. The Title V Adolescent Health coordinator will continue participating in meetings and activities regarding the state plan.

In 12/03, a team of health and human services leaders, legislators, and program level-staff attended the Collaboration Around Youth Suicide Prevention Conference. In this forum, Texas and 6 other states further developed their state suicide prevention plans while receiving the guidance and feedback of national experts. The state team identified 5 priorities that included sponsoring a resolution/call to action by the Governor tied to National Suicide Prevention Week, an awareness raising campaign, a Fall 04 summit, developing linkages between the SSPP and the Texas State Strategic Health Partnership-Mental Health Component, as well as developing linkages between the Texas Mental Health and Texas Medical Associations. Other action items resulting from this meeting or follow-ups to it included preparation of a suicide education and awareness legislative briefing and the researching of evidence-based suicide interventions for possible duplication in Texas.

In 12/03, Texas Title V staff, as well as other state agency and private partners, also attended the Bi-Regional Suicide Prevention Training Conference "Taking Action: Implementing the National Strategy for Suicide Prevention." Outcomes for Texas from this conference included the establishment of an Executive Steering Committee for identifying the mechanism for identifying stakeholders, planning a future meeting, creating timelines, monitoring implementation progress and securing future funding.

The Texas Suicide Prevention Network (TSPN) has been recognized as an official sub-committee for the Texas State Strategic Health partnership discussed in the needs assessment appendix. Activities for the TSPN include the establishment of 2 ad-hoc committees. The committees will focus on public awareness and the development of a process to garner support for suicide prevention efforts. Partnership representatives have also conducted presentations to community and professional organizations about the issue in general and statewide efforts underway to address the issue.

### c. Plan for the Coming Year

Activity 1: Participate in the Texas Suicide Prevention Partnership in the continued implementation of the state suicide prevention plan.

Output Measure: Number and type of activities implemented; summary report of activities and outcomes resulting from implementation of activities.

Monitoring: Quarterly reporting of specific activities.

Evaluation: Assess the change in the rate (per 100,000) of suicide deaths among youth aged 15 through 19.

### a. Last Year's Accomplishments

Activity 1: Continue the implementation of training and consultation with public health regional staff to establish a regional perinatal care system in order to facilitate interventions to reduce VLBW and other perinatal conditions in their regions.

Update: In FY 03, a presentation was made in PHR 11 to provide regional staff, local providers, and local health department staff with Geographic Information Systems data about the establishment of regional perinatal systems of care. Due to resource limitations, no additional consultations have been held with health care providers and no work has been done with providers and stakeholders to encourage the implementation of perinatal systems. This activity may resume in the future should funding and other resources be made available.

Performance Assessment: As in FY 02, the percentage of FY 03 VLBW deliveries at facilities for high-risk deliveries and neonates remained below the 55% objective at 52.9%. This percent has remained relatively consistent over the last 5 years. Efforts to improve Texas' progress on this measure include enhanced education and ongoing efforts to identify existing perinatal systems.

### b. Current Activities

Activity 1: Develop and implement a process for the self-designation of perinatal care facilities as basic, specialty or subspecialty.

Update: A self-designation process was discussed and drafted at the Perinatal Systems meeting in Nov. 03. Title V staff was also tasked during this meeting to learn more about information already collected by TDH around levels of care designation. During recent months, TDH leadership decided to temporarily discontinue this workgroup due to the many organizational changes currently underway at TDH and no other action on this activity has been undertaken.

### c. Plan for the Coming Year

Activity 1: Ensure the continued assessment of perinatal care facilities as basic, specialty or subspecialty.

Output Measure: Develop and disseminate a list of facilities classified according to level of care. Develop and implement a process for updating the list regularly.

Monitoring: Track developments related to development and implementation of process. List perinatal care facilities by designation on the program's website.

Evaluation: Assess the long-term changes in the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

### a. Last Year's Accomplishments

Activity 1: Continue to assess the level and type of interventions needed for each geographic area and related sub-populations at risk (Hispanic and African American women of childbearing age) 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

Update: A total of 67 Title V contractors provide prenatal care. Together they serve a total of

69,491 unduplicated prenatal clients. In FY 03, 1 presentation was made in PHR 11 to provide regional staff, local providers, and local health department staff with data about early entry to prenatal care in the region.

Performance Assessment: Despite Texas' continuous efforts, the percentage of infants born to pregnant women receiving prenatal care in their first trimester remains a challenge for Texas. As in previous years, Texas FY 03 reported 80.8% falls below the objective set at 85%. There continues to be room for improvement, especially because the percentage of women who access prenatal care differs greatly by race and ethnicity. TDH efforts continue to focus on infrastructure building activities and models of care to address this problem. Ongoing efforts include education, technical assistance to providers, and targeting minority areas and improving the core perinatal infrastructure.

## b. Current Activities

Activity 1: Provide county specific data fact sheets regarding entry into prenatal care to regional Title V staff and local health care providers. Provide information on strategies to increase the percent of infants born to women receiving prenatal care beginning in the first trimester to regional staff and health care providers. Provide data and information on the Perinatal Health website.

Update: The TDH Center for Health Statistics developed data reports focusing on perinatal health issues for each Texas PHR. The reports include information on entry into prenatal care and strategies to increase early entry into prenatal care. Title V staff continues to work with the Center to tailor these reports to best meet the needs of regional staff. Successful strategies being researched further include the concept of group prenatal care and the Friendly Access Program operating out of the Lawton and Rhea Chiles Center for Healthy Mothers and Babies (<http://www.chilescenter.org/programs4.htm>). Title V staff are also discussing the possibility of hosting a training on group prenatal care for Title V contractors and have contacted New Mexico Health Department staff regarding similar centering pregnancy efforts in their state.

Activity 2: Work with March of Dimes and Area Health Education Centers to train Promotoras/Community Health Workers to provide folic acid information and multi-vitamin samples to women of childbearing years.

Update: During FY 04, multivitamins were ordered and a plan was developed for disseminating multivitamins to promotoras/community health care workers. An order form, which is distributed at promotora training events, was developed to order the multivitamins and promotional materials. As of June 04, TDH had distributed more than 2,000 units of vitamins to promotoras.

Activity 3: Improve the outcomes of pregnancies impacted by diabetes among the African American and Hispanic populations through the provision of data and technical assistance to the public health regions, local health care providers and the general public.

Update: Title V staff focusing on perinatal health issues are in the process of modifying data reports for each public health region. The data reports include information on the impact of Type I and Type II diabetes on pregnancy. Development on the perinatal health website continues.

## c. Plan for the Coming Year

Activity 1: Provide region specific data fact sheets regarding entry into prenatal care to regional Title V staff and local health care providers targeting high risk, high prevalence areas. Provide information on strategies to increase the percent of infants born to women receiving prenatal

care beginning in the first trimester to regional staff and health care providers. Partner with TDH Quality Assurance Program to assess access to care among TDH contractors. Provide data and information on the Perinatal Health website.

Output Measure: Number of region specific data fact sheets developed; number of effective interventions from other states reviewed; number and type of strategies to increase prenatal care among African Americans and Hispanic women provided to providers and stakeholders; partnership established with TDH Quality Assurance Program to assess access to care among TDH contractors; number of completed assessment tools regarding access to care.

Monitoring: Document provision of data and strategies to providers located in geographic areas with high percentages of women not receiving prenatal care beginning in the first trimester.

Evaluation: Analyze and profile regional based or other geographical areas with a high occurrence of infants born to women receiving late or no prenatal care, before and after implementation of the strategies.

Activity 2: Improve the outcomes of pregnancies impacted by diabetes among the African American and Hispanic populations through the provision of data and technical assistance to the public health regions, local health care providers and the general public.

Output Measure: Number of data reports on diabetes-impacted pregnancies given to public health region staff and local health care providers; number and types of technical assistance provided to public health region staff and local health providers regarding the impact of Type I and Type II diabetes on pregnancy; number and type of Information placed on Perinatal Web page about the impact of Type I and Type II diabetes on pregnancy.

Monitoring: Monitor hits to Perinatal Program website; document technical assistance sessions provided; and development and dissemination of data reports.

Evaluation: Track large for gestational age births by region and race.

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Reduce the number of unsatisfactory specimens by identifying providers who submit unsatisfactory specemens in order to provdem them educational materials on specimen collection and handling procedures.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Educating parents and health professionals about NBS benefits and requirements by providing printed materials, maintaining a website and providing technical assistance.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Continue formal and informal mechanisms for partnering in decision making with families of CSHCN and promoting family network through diverse forums.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Require and confirm that all service contractors have quality assurance plans and provide technical assistance and training to service contractors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Inform CSCHN medical providers and families of the principles and practice of providing/obtaining and using a medical home through the Medical Home Workgroup and through dissemination of materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Document case management efforts to connect CSHCN with medical homes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Document payment of insurance premiums to help families maintain private insurance.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Document provision of health care benefits to those eligible for CSHCN services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Document number of CSHCN on waiting list by age and region with no other source of insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Continue to fund contracts to support community-based service systems' infrastructure and coordination.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to publicize and gather/monitor public input and feedback on the program and service delivery via the toll-free information and referral line, as well as the CSHCN Program website.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue participation in state-level advisory groups, task forces, committees, and similar forums that are working on issues pertaining to CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who				

received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Participate in the Leadership Education in Adolescent Health (LEAH) Advisory Board and document CSHCN staff roles, responsibilities, activities and outcomes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide articles and references on best practices and education/training tools on transition for CSHCN for families of and/or providers via the Family Newsletter, Provider Bulletins, CSHCN website and via mail.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. As a Healthy Child Care America grantee, develop a plan with the TDH Immunization Division to promote timely, age-appropriate immunizations through the use of IMMTRAC (Texas immunization registry) system by child care centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Develop and provide, via the Internet, resource materials to raise public awareness of teen pregnancy in Texas.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide funding to community-based organizations to promote				

abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide funding to Title V contractors for population-based activities and family planning services to reduce and prevent pregnancy among adolescents and teenagers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide funding to Title XX contractors for family planning activities to reduce and prevent pregnancy among adolescents and teenagers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Continue providing dental sealants to Texas' 3rd grade population.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Provide traffic-seat safety presentations to children ages 0-8 regarding car seat safety.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide high-quality safety seats and education concerning their use to low-income families through a distribution program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Monitor breastfeeding rates of mothers using available data from Ross Labs, WIC, and PRAMS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Improve community access to education and support resources to promote breastfeeding by providing multiple venues including a website and funding community breastfeeding education initiatives.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps and Baby Friendly Initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Conduct monitoring of newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

13) Percent of children without health insurance.				
1. Monitor and report number of children without health insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Continue to assess the level and type of interventions needed for each target area and related sub-populations at risk and provide regional staff and health care providers with data and information on strategies to reduce VLBW live births.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide ongoing support to continue implementation of the Pregnancy Risk Assessment Monitoring System.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work closely with the March of Dimes 5-year Prematurity Campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

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

1. Work with key stakeholders in enlisting broad base support for a statewide suicide prevention plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

1. Develop and implement a process for the self-designation of perinatal care facilities as basic, subspecialty, or specialty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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1. Provide county specific data fact sheets regarding and on strategies to improve entry into prenatal care to Title V staff and local health care providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with March of Dimes and Area Health Education Centers to train Promotoras/Community Health Workers to provide folic acid information and mult-vitamin samples to women of childbearing years.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Improve the outcomes of pregnancies impacted by diabetes among select minority populations through the provision of data and technical assistance to public health regions, local health care providers and the general public.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Change in institutionalized CSHCN, as percent of previous year.*

a. Last Year's Accomplishments

Activity 1: Participate in the Children's Policy Council (CPC) to collaborate with consumers, providers, and other agencies to support community living options for CSHCN in institutions and congregate care facilities.

Update: In FY 03, the CPC with 18 public members, including 9 family representatives, and 1 youth member, met 3 times. Meetings focused on legislative issues relating to long-term care and supports for children with disability and special health care needs and on reviewing the changes mandated by the transformation of HHS agencies. In FY 03, CPC authored a report, "And How are the Children?- Recommendations for improving the Well-Being of Children and Disabilities in Texas," (available online at [www.hhsc.state.tx.us/si/cpc/02CPCrpt.htm](http://www.hhsc.state.tx.us/si/cpc/02CPCrpt.htm)). The CPC spent 2 years analyzing the status of the systems of long-term care and family supports available to Texas children and the report contains many recommendations indicating substantial unmet need. Recommendations include not admitting any children to institutions, expanding family-based alternative projects and funding permanency planning efforts, etc.

Activity 2: Provide family support services (FSS) for CSHCN and their families to enable CSHCN to live with their families in the community.

Update: During FY 03, 4 families received FSS (medical foods) though the program's fee-for-service benefits. At FY end, only 2 families continued to receive assistance as the other families relocated out-of-state. Additional families did not receive FSS due to program and department budgetary constraints. Children served by case management and community/family resource services contractors continued to receive FSS such as support groups and activities, educational workshops, networking with other families, etc. In each FY 03 quarter, between 1800 and 2563 families received these types of services from case management and community/family resource services contractors. CSHCN's rules stipulate that if the CSHCN Program has a waiting list in order to achieve budget alignment, the

program shall provide FSS limitedly.

Performance Assessment: Texas' data show a decrease in children in institutions from FY 00 to FY 03 of 8.9%. FY 05 planned activities impacting this measure will help work toward keeping children out of institutions as well as moving children from institutions into family settings. Activities include working with the CPC in developing policy and legislative recommendations to address this issue; continuing to provide FSS through contractors and the health benefits program; and working with Promoting Independence to foster policies to move children from institutions to community-based family settings.

#### b. Current Activities

Activity 1: Participate in state-level committees/task forces to collaborate with consumers, providers, and other state and private agencies to support permanency planning and community living options for CSHCN who are at risk for placement or who currently reside in institutions and congregate care facilities.

Update: CSHCN program staff participates in 11 statewide groups addressing issues of children or adults at risk of being placed in institutions. To-date in FY 04, most of the groups have met at least once. Major issues addressed at the statewide groups include improving access to children's services, ensuring that children's issues and that expertise in children's policy and programs not get lost in the HHS system transformation, improving transition to adult services, preserving and enhancing effective interagency collaboration in serving children with complex needs and fostering self-determination among CSHCN as they mature and transition to adults services. Issues of concern voiced at these meetings include concern about reductions in state budgets for health and human services for children and the potential for increasing institutionalization of children. CSHCN staff also participates in the statewide CPC meeting and activities to develop recommendations to state leadership regarding permanency planning and deinstitutionalization of children.

Activity 2: Provide family support services for CSHCN and their families to enable CSHCN to live with their families in the community.

Update: To date in FY 04, contractors provided FSS to 2,983 families of CSHCN. Currently there is a waiting list for the CSHCN Program health care benefits and only limited family support services are offered outside of those provided by contractors. When there is a waiting list for CSHCN Program health care benefits, in order to receive family support services, a child must be an on-going client at risk of institutionalization or it must be shown that provision of family support services are cost effective for the CSHCN Program. As of May 04, limitations on the CSHCN Program's FSS coverage of FSS remain in place since the program continued to have a waiting list for health care benefits.

During the second quarter of FY 04, the Program finalized changes to forms related to documentation requirements for family support services. A step-by-step procedure for implementation of various policies related to family support were defined and a training tool was developed to train regional staff and then providers and clients/families in the implementation of the Program's FSSs.

#### c. Plan for the Coming Year

Activity 1: Participate in state-level committees/task forces to collaborate with consumers, providers, and other state and private agencies to support permanency planning and community living options for CSHCN who are at risk for placement or who currently reside in institutions and congregate care facilities.

Output Measure: Types of activities involved in and completed.

Monitoring: Documentation of meetings attended by CSHCN Division staff.

Evaluation: Document and assess annual outcomes and products relevant to CSHCN in institutions.

Activity 2: Provide 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 family support services through the CSHCN Program's fee-for-service health care benefits or through the CSHCN Program's service contracts; number of CSHCN clients and their families requesting but not receiving family support services; number of CSHCN who request CSHCN family support services because they are at risk for institutionalization.

Monitoring: Track CSHCN program utilization, track the number of CSHCN on the waiting list; track expenditures for family support services.

Evaluation: Assess the extent to which families requesting family support services are served.

## State Performance Measure 2: *Percent of children and adolescents (aged 13-19) who chose healthy behavior.*

### a. Last Year's Accomplishments

Activity 1: Provide training on youth risk reduction and youth health promotion to health care and education professionals at regional Education Service Centers.

Update: Texas currently has 20 Education Service Centers (ESC). ESCs are tasked with assisting school districts and charter schools in improving student performance and increasing the efficiency and effectiveness of school operations. In FY 03, ESC staff provided training on a number of different topics including tobacco abuse, substance abuse (drug and alcohol), teen pregnancy, sexually transmitted diseases, motor vehicle deaths/injuries, homicide, and suicide. During FY 03, 939 workshops were conducted for a total of 24,269 health care or educational professionals completing a total of 128,215.25 clock hours of training. Participants completed evaluations with an average of 4.8 on a scale of 1 through 5 (with 5 representing excellent).

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.

Update: During FY 03, the Abstinence Education Program (AEP) served a total of 402,243 clients and funded a total of 33 contractors located in 10 of TDH's 11 PHRs. The number of clients served by the AEP in FY 03 increased by 9,442 clients over FY 02 reported figures. This slight increase may be, in part, attributed to an increase of 2, for a total of 33, AEP funded contractors throughout Texas. All regions, except for PHR 5 (East Texas) and PHR 10 (Midland), have at least 1 AEP contractor.

Performance Assessment: Data for FY 03 indicate an increase in the percent of children choosing healthy behaviors, from 60.1% in FY 02 to 63.4% in FY 03, though still falling short of the objective of 72%. Many Title V activities are already in place and positively influence this measure and include medical and dental check-ups, immunizations, child safety seat education and distribution, and others.

## b. Current Activities

Activity 1: Provide training on youth risk reduction and youth health promotion to health care and educational professionals at regional Education Service Centers.

Update: During FY 04, Education Service Centers statewide have delivered 756 workshops focusing on multiple topics that include tobacco, injury and teen pregnancy prevention and sexually transmitted diseases. A total of 18,036 participants clocking 87,067 clock hours of training have completed the training. The average workshop evaluation, with 5 representing excellent, is 4.5 out of 5.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.

Update: The Abstinence Education Program (AEP) has 42 contractors in FY 04, with at least 1 contractor in each TDH public health region. To date in FY 04, the AEP has served 255,797 clients.

## c. Plan for the Coming Year

Activity 1: Provide workshops on youth risk reduction and youth health promotion to health care and educational professionals at Texas' regional Education Service Centers (ESC).

Output Measure: Number of workshops provided, number of participants and clock hours of training.

Monitoring: Track scheduled presentation on a quarterly basis.

Evaluation: Document and review evaluations at each Regional ESC for overall satisfaction with curriculum provided.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities. (Same as Activity #2, National Performance Measure 8 -- birth rate).

Output Measure: Number of unduplicated clients served including: teens/children, parents and health providers that are provided with abstinence education information. Document the age, ethnicity, and service delivery area served for unduplicated clients. Number and type of contacts made or received from community based organizations regarding abstinence education.

Monitoring: Review abstinence contractor reports of the number of unduplicated clients and the areas served on a monthly basis. Provide technical assistance to improve overall contractor performance.

Evaluation: Determine contractor goals for the projected number of clients to be served, and review contractor performance from monthly reports.

## State Performance Measure 3: *Percent of infants and children (aged 0-12) who will thrive.*

### a. Last Year's Accomplishments

Activity 1: The Take Time for Kids Program will contract with Texas A&M Extension Service to continue conducting the parent education train-the-trainer workshops for professionals, child

care staff and community leaders. The purpose is to increase parent's knowledge and skills about the importance of check-ups, immunizations, and other children's health issues.

Update: Texas' Cooperative Extension organized and conducted 8 parent education workshops, in 7 different locations throughout Tx., for a total of 488 community professionals and volunteers. Participants included other state agencies, Head Starts, school districts, and child care center and day care programs. Workshops covered the importance of immunizations, child growth and development, safety, and nutrition, etc. Overwhelmingly, participants indicate satisfaction with the training.

Activity 2: Provide traffic-safety presentations to children ages 0-8 regarding bicycle and car seat safety.

Update: In FY 03, the Safe Riders Traffic Safety Program provided 65 child passenger safety presentations to 1,341 children/adults. Children and adults are polled after the presentations, with both demonstrating enhanced understandability and learning of the material presented.

Activity 3: Provide high-quality safety seats (for children from birth to age 8) and education concerning their use to low-income families through a distribution program.

Update: 12,760 safety seats for low-income families were ordered and distributed to 113 safety seat distribution programs. This total is 7,531 less than FY 02 purchases due to decreased funding availability. 1,696 of the total seats were targeted for distribution in 9 urban and Texas/Mexico border distribution sites showing lowest seat utilization rates and with a documented need for safety seats. A total of 221 people affiliated with the distribution sites were trained by staff and 8 on-site technical assistance visits were made.

Activity 4: Promote, facilitate and disseminate the philosophy, methods and model strategies that promote the development of resiliency and other protective factors among children aged 15-19 years.

Update: Due to funding shortfalls and a focus on other departmental priorities the activities related to this measure were not completed or evaluated. The program supporting this measure was disbanded, however staff retain some of the learned philosophies relative to youth development and resiliency and incorporate such, as appropriate, into current activities and roles.

Performance Assessment: As with State Performance Measure 2 relating to healthy behaviors a review of data relative to this measure continues to show slow steady progress toward the 78% objective, from 53% in FY 02 to 57.6% in FY 03. Synergistically, the activities supporting these 2 measures positively impact health outcomes for Texas' children.

## b. Current Activities

Activity 1: Develop a statewide Early Childhood System (ECS) in conjunction with internal and external stakeholders. Recommendations will be included in a comprehensive state plan and presented to the Associateship of Family Health.

Update: A steering committee tasked with developing a Statewide ECS system met in 10/03. During the meeting 5 work groups focused on access to medical homes/health insurance, parent education, family support, early care and education, and social-emotional development/mental health. Groups meet monthly and seek technical assistance as needed. Each workgroup is tasked with developing a plan for their component. TDH Title V staff

dedicated to this activity recently transferred to Texas' Health and Human Services Commission (HHSC), Office of Early Childhood Coordination (OECC). TDH and HHSC have contracted with the Univ. of Tx. to evaluate the planning process, to review developed plans, and to make recommendations and provide assistance with holding focus group discussions. Work plans should be complete by Fall 04, giving the larger group 6 mos. to integrate them into a comprehensive state plan, seek stakeholder input and seek approval. OECC staff have developed and distributed a survey for professionals to obtain statewide feedback on what professionals view as major issues for each of the components. In late FY 04, 8 parent-focused focus groups are planned to solicit input.

Activity 2: Provide traffic-safety seat presentations to children ages 0-8 regarding car seat safety.

Update: Since 9/03, the Safe Riders Traffic Safety Program has provided 69 presentations to a total of 2951 adults and children. 26 of the presentations were given to 1,437 children ages 8 and under.

Activity 3: Provide high-quality safety seats and education covering their use to low-income families through a distribution program. Seats provided for children from birth to age 8.

Update: During FY 04, safety seats were distributed from 5/04-6/04 by 95 distribution sites. 100% of the organizations distributing seats attended a 4-hour safety seat training in order to be able to issue seats. The 96 organizations received and will distribute 11,398 seats.

Activity 4: In the continued effort to create a statewide suicide plan (SSP) work with with key stakeholders in enlisting broadbased support through a grassroots campaign through Texas.

Update: The Title V Adolescent Health Coordinator continues to participate in meetings and activities related to the state plan. She and a team of HHS leaders, legislators and staff attended the Collaboration Around Youth Suicide Prevention Conference. In this forum, Texas and 6 other states developed their SSP while receiving national experts' feedback and guidance. Texas' team identified 5 priorities including an awareness raising campaign, a Fall 04 summit and developing linkages among partners. Partners also have presented on the issue and the statewide effort.

### c. Plan for the Coming Year

Activity 1: In collaboration with HHSC's Office of Early Childhood Collaboration, and in conjunction with both external and internal stakeholders, participate in the development of a statewide Early Childhood System.

Output Measure: Number and types of recommendations to be included in the comprehensive state plan.

Monitoring: Track the process of plan and recommendations development.

Evaluation: Assess the planning process for effectiveness of the development of an early childhood system and assess the number of recommendations made and implemented.

Activity 2: Provide Child passenger safety presentation to children ages 0-8 regarding car seat safety.

Output Measure: Number of presentations conducted statewide; number of children/adults attending each presentation.

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

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

Activity 3: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8.

Output Measure: Number of seats distributed statewide.

Monitoring: Track development and progress of distribution program.

Evaluation: Assess the effectiveness of the project by reviewing data from the Texas Transportation Institute on statewide child restraint usage in comparable areas.

#### State Performance Measure 4: *Ratio of Black low birth weight rate to White low birth weight rate.*

##### a. Last Year's Accomplishments

Activity 1: Promote smoking cessation to African-American women ages 13-44, including pregnant women in PHR 2,3,4,5,6 by informing providers about smoking cessation programs and distributing smoking cessation counseling.

Update: During FY 03 funds were not available to expand the smoking cessation program to these regions. In FY 03, there were 374 unduplicated calls made to the Great Start Smoking Cessation Line (GSSCL) with the system recording that 74 callers were pregnant. There were 1619 unduplicated calls made to the Quitline Smoking Cessation Line, by women aged 13-44, with 60 reporting they were pregnant. Pregnant callers are then automatically referred to the GSSCL.

Activity 2: Develop and provide a 2-hr. training session with CEUs and web-based educational materials for providers on low birth weight and prematurity, to include an overview of the problem statistics and impacts of LBW births.

Update: Title V perinatal staff worked with the Shaken Baby Alliance, other stakeholders, and health care and public health professionals to develop an 8 hr. train-the-trainer curriculum entitled the "Infant Mortality Prevention Education Program" (IMPEP). The curriculum includes 4 sessions including perinatal issues, SIDS, accidents and abuse and neglect and includes Power Point presentations, an in-depth support curriculum and many references and handouts. Development of the IMPEP began in the 4th qtr of FY 02 and the IMPEP training and curriculum development was completed in the 1st quarter of FY 03. Training began in 1/03 and was conducted in the 11 PHRS. The Title V perinatal coordinator has presented the Perinatal Issues section at all but 1 of the IMPEP trainings. The Perinatal website is currently in development and will be available on the planned website, likely in FY 04. Training is presented to a wide variety of individuals from health care providers to law enforcement personnel.

Performance Assessment: FY 03 data indicate that the ratio for this measure was 1.8, as it was in FY 03 and still above the 1.6 target ratio. Provider and client focused smoking cessation activities for pregnant women and education will continue into FY 05.

##### b. Current Activities

Activity 1: Promote smoking cessation to African-American women ages 13-44, including

pregnant women in TDH Public Health Regions 5 (Tyler) and 6 (Houston) by informing providers about smoking cessation programs and distributing information about smoking cessation counseling.

Update: As of Feb. 04, 15 unduplicated calls by women aged 13 through 44 have been made to the Great Start Smoking Cessation line. This line is specifically designed for pregnant callers. There were 751 unduplicated calls made to the Quitline Smoking Cessation Line by women aged 13 through 44 during this same time frame. This line targets all women, however when a pregnant woman is identified she is referred automatically to the Great Start Smoking Cessation Line. Funding dedicated to this activity was reduced by over 50% of FY 03 levels and has resulted in lower overall call volume and reduction in media expenditures promoting the availability of hotlines.

### c. Plan for the Coming Year

Activity 1: Promote smoking cessation to African-American women ages 13-44, including pregnant women in TDH Public Health Regions 5 (East Texas/Gulf Coast area) and 6 (Houston) by informing providers about smoking cessation programs and distributing information about smoking cessation counseling.

Output Measure: Number of providers contacted; numbers and type of smoking cessation materials; number of Smoking Cessation awareness events targeting African American women planned; number of calls made to the Quitline by non-pregnant women ages 13-44 by race and ethnicity; number of calls to Quitline by pregnant women by race and ethnicity.

Monitoring: Posting of the educational materials on the web-site completed; number of training sessions provided, number of participants completing training; track number of calls to the Quit line.

Evaluation: Assess changes in low birth weight births in TDH Public Health Regions 5s and 6.

## State Performance Measure 5: *The prevalence of childhood obesity.*

### a. Last Year's Accomplishments

Activity 1: Continue the development of the state plan to prevent and control obesity and the development of a marketing plan to promote the adoption of the state plan into internal and external organizations action strategies.

Update: The Strategic Plan for the Prevention of Obesity in Texas (SPPOT) was released during the Promoting Healthy Weight in Tx. conference and distributed to all attendees. The plan contains 4 goals with objectives to address the obesity epidemic in Tx. The 4 goals center around increasing awareness of the problem of obesity, monitoring and disseminating data, creating collaborations that create opportunities to make lifestyle choices that support good nutrition and physical activity and policy and environment changes that lead to or promote healthful eating habits and physical activity. FY 04 plans include implementation of the plan by a steering committee with sub-committees formed around each of the 4 goals. During FY 03, TDH chose 10 communities to receive competitive mini-grants of \$4,999 to develop or improve a community trail, promote it, or evaluate the trail's use. This project addresses goal 3 of the state plan dealing with promoting policies and environmental changes to support healthful eating habits and physical activity. For example, in FY 03, 1 Houston area organization used the state plan for nutrition and physical interventions. Goals of that effort are to treat and prevent children and adolescents from becoming overweight by developing a community-based program. The plan (available at <http://slehc.org/slehc>) will be piloted in Houston's East End community which is medically underserved, low income and Hispanic. During FY 03, TDH was also awarded a 5 yr. grant from CDC to prevent obesity and chronic disease. As part of

this grant, TDH staff conducted a planning process in collaboration with partners that expanded the SPPOT to be comprehensive and include an evaluation plan. A 47 member subgroup of the Texas Strategic Health Partnership was formed to help achieve these expanded activities.

Activity 2: Contract with the University of Texas-Austin to help implement health promotion activities at intervention schools to address proper nutrition and physical activity in the target population.

Update: During FY 03, the contract was approved and interventions completed. The social marketing and physical activity interventions included building running tracks, purchasing basketballs and implementing changes to classroom lessons to make lessons more active. Evaluation is ongoing and will be reported on in future years.

A performance assessment for this section is attached.

#### b. Current Activities

Activity 1: The Texas State Strategic Health Partnership Workgroup will expand the "Strategic Plan for the Prevention of Obesity in Texas" to be a comprehensive state plan. The plan will address 1) obesity prevention and control including caloric expenditure and intake; 2) increased consumption of fruits and vegetables; 3) increased physical activity; 4) reduced television time; and 5) increased breastfeeding.

Update: In Oct. 03, a 47 member workgroup of the Texas State Strategic Plan, representing a diversity of both public and private organizations, met to bring together statewide partners to develop action items to accomplish the priority action items highlighted earlier in this application and to develop next steps toward accomplishing action items. This workgroup is composed of 4 subgroups with each subgroup assigned 1 of the goals in the Strategic Plan for the Prevention of Obesity in Texas. Since the beginning of FY 04, the 4 subgroups have had several conference calls to continue working on their action items, which include recommendations for policies to improve nutrition and physical activity, conducting focus groups to develop appropriate obesity-prevention messages, review of community kits to promote healthful eating and increased physical activity, and recommendations for obesity surveillance. TDH staff working with the workgroup has developed a timeline for updating the Strategic Plan for the Prevention of Obesity in Texas, and will be working with the workgroup and other statewide partners to get stakeholder input before the plan is updated. The update, as detailed, in plans for the coming year, will be a compendium to the original plan that provides a comprehensive implementation guide.

Activity 2: Contract with the University of North Texas Health Science Center (UNTHSC) to conduct social marketing research to develop messages to use with the implementation of the "Strategic Plan for the Prevention of Obesity in Texas."

Update: The contract was developed and executed with the UNTHSC. The UNTHSC conducted a literature review, reviewed Texas obesity data, and had several conference calls with the workgroup subgroup to discuss the target audience for the social marketing campaign. Currently, the contractor is conducting focus groups with Hispanic school children aged 9 through 13 and their parents to identify appropriate messages for a social marketing campaign.

#### c. Plan for the Coming Year

Activity 1: Working with statewide partners, TDH staff will develop an Implementation Guide for

the Strategic Plan for the Prevention of Obesity in Texas. The Implementation Guide is planned to target communities, schools, businesses, and other organizations interested in identifying obesity-prevention activities that they may be able to implement at their level.

Output Measure: Implementation Guide developed and completed.

Monitoring: Follow progress on development of the Implementation Guide.

Evaluation: Document dissemination of the guide and follow up with recipients to determine how many organizations, businesses, etc have implemented 1 or more recommended obesity-prevention activities from the Implementation Guide.

Activity 2: Working with the Goal A Workgroup of the Texas State Health Strategic Partnership, develop a comprehensive distribution plan for distributing the Implementation Guide

Output Measure: Follow progress on development of plan; report number of copies distributed and/or hits to the website where the Implementation Guide will be available.

Monitoring: Follow progress on development of plan; report number of copies distributed and/or hits to web site where the Implementation Guide is located.

Evaluation: Using feedback from those receiving guide, access any secondary distribution efforts, and identify new partners in the statewide obesity-prevention initiative.

## State Performance Measure 6: *Incidence of carious lesions among school children in Texas.*

### a. Last Year's Accomplishments

Activity 1: Conduct statewide survey of caries prevalence among school children in Texas.

Update: Of 17,874 school children examined statewide, 5,598 or 31.3% exhibited active caries. This represents a significant reduction in the 31,566 children examined in FY 02 primarily due to staff vacancies and focus of staff on other activities and department priorities. Title V and TDH staff notify parents whose children have active caries and recommend that the parent seek dental care for their child.

Activity 2: Promote the health benefits of community water fluoridation, maintain existing fluoridation systems, and provide upgrades to existing fluoridation systems at the community level if funding is available.

Update: The Texas Fluoridation Project provides assistance and monitors public water systems that adjust the fluoride level in the drinking water. The project provides services to meet the national objectives of Healthy People 2010 to reduce dental caries. During FY 03, grants were made for a total of \$163,032 to upgrade equipment at 5 water systems and to provide injection equipment at 2 new wells. In FY 03, the cities of Tomball, Beeville and Paris upgraded their water fluoridation systems. Universal City began adding fluoride to a newly installed well and Pineland City began adding fluoride to their water system. Fluoridation maps for Texas are accessible on the Internet through the Centers for Disease Control and Prevention Water Fluoridation Reporting System (WFRS). Using current WFRS data, 16,291,953 (or 74.8%) of the Texas' total population (21,779,893) receive fluoridated water. Differences in how the optimal fluoride value is now calculated (0.6 ppm instead of 0.7 ppm) account for, in part, the difference from FY 02 reported figures.

Performance Assessment: There were 5,598 third- to seventh-grade children with carious lesions in FY 03. The incidence of carious lesions among school children in Texas dropped from 43.2 in FY 02 to 31.3 in FY 03, markedly lower than the performance objective of 43.

Dental screenings will continue in FY 05 along with education and technical assistance provided on the benefits of both sealants and fluoridated water.

#### b. Current Activities

Activity 1: Conduct statewide survey of caries prevalence among school children in Texas.

Update: From Sept. 03 through Nov. 03 TDH regional dental staff examined 7,683 school children statewide and found that 5,281 or 69% had caries present. Parents are notified of presence of dental caries and are advised to follow-up with their family dentist.

Activity 2: Promote the health benefits of community water fluoridation, maintain existing fluoridation systems, and provide upgrades to existing fluoridation systems at the community level if funding is available

Update: To-date in FY 04, grants were awarded for a total of \$134,137 to upgrade equipment at 5 water systems (in East Texas and the Gulf Coast Area) and to provide fluoridation equipment to 1 new system in East Texas (Jasper City). Engineering designs were completed for each grantee. Fluoridation system designs were also provided to 6 water systems that were not grantees and included the San Antonio Water System, Bexar Met, and other Central Texas (greater Austin area) locations. The program has also inspected 40 public water systems statewide that fluoridate and conducted 1 operator training class. A total of 162 water operators attended the classes focusing on the benefits of water fluoridation, chemical safety, equipment design, and testing procedures. The program is also continuing to add, correct, and validate fluoridation data through the Centers for Disease Control and Prevention Water Fluoridation Reporting System (WFRS).

#### c. Plan for the Coming Year

Activity 1: Conduct statewide survey of caries prevalence among pre-school and or school age children in Texas.

Output Measure: Number of preschool and/or school-aged 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.

Activity 2: Promote the health benefits of community water fluoridation, maintain existing fluoridation systems, and provide upgrades to existing fluoridation systems at the community level if funding is available

Output Measure: Number of fluoridated community systems maintained and number of upgrades to existing fluoridation systems.

Monitoring: Track location of each system maintained or upgrade to system and number of individuals served by fluoridation system.

Evaluation: Measure the increase in systems and populations served.

State Performance Measure 7: *Percent of female clients suspected of being victims of relationship violence.*

## a. Last Year's Accomplishments

Activity 1: Distribute family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers.

Update: In FY 03, program staff continued to distribute educational materials about family violence/sexual abuse prevention to providers, educational institutions, and the general public. During FY 04, a total of 3,232 pieces of educational materials were distributed and included male and female teen dating violence brochures and posters. During FY 03 the questionnaire to assess the usefulness of the materials was not developed due to a focus on other program priorities.

Activity 2: Through the program website, provide accessible abuse prevention and youth development training to Title V providers, PHR staff and other interested health care providers.

Update: During FY 03, 1 module, "Caring for the Adolescent Patient: Preventing Sexual Coercion," was developed and made available only and is currently only accessible to family planning providers. Originally, 3 modules were planned but with development 1 consolidated module resulted. During FY 03, no counter existed on the website, but program staff have received 42 feedback forms with generally positive comments from individuals taking the course, 8 of whom have requested CEUs.

Activity 3: Apply to the CDC-P for a 1-yr funding grant to support the development of a strategic plan to prevent domestic violence.

Update: In 9/02, TDH received a \$50,000 grant from CDC-P to develop a strategic plan to prevent violence against women. Texas' plan was completed in 9/03 and focuses on primary prevention. A stakeholder group, the Violence against Women Advisory Council (VAWPAC) formed and met regularly to develop a strategic plan. 3 areas were identified as the focus for making primary prevention of the targeted issues of sexual assault, domestic violence, and stalking a public health priority and include data and its correlation to the problem, practices to shift to a culture that does not tolerate the targeted issues and the importance of public awareness strategies in addressing this problem. Next steps include seeking both policy and legislative level endorsement for plan implementation.

Performance Assessment: In FY 03, the percentage of female clients suspected of being victims of relationship violence was 3.7%, slightly lower than the percent reported in FY 02 of 3.8%. Data continues to show no significant improvements over past years perhaps validating the difficulty in addressing the breadth of this issue. Activities planned for FY 05 include ongoing education and technical assistance as well as monitoring activities of the Texas Association Against Sexual Assault.

## b. Current Activities

Activity 1: Distribute family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers.

Update: Title V staff continue to distribute educational materials and other items on family violence/sexual abuse prevention that includes 2 posters and 2 brochures. One brochure is entitled "Guys, How is your Relationship?," targets males, while the other poster and brochure target females and is entitled "Clueless about Domestic Violence." Twelve entities have requested additional materials and most have received 1 or more of these publications. A total of over 600 individual posters and brochures have been distributed.

Activity 2: Through the program website, continue providing accessible abuse prevention and

youth development training to Title V providers, TDH regional offices, and other interested parties.

Update: In Jan. 04 program staff completed the first training module on sexual coercion. There have been 67 hits to the training module website. Currently the module is located on a password protected section of the website. There have been no requests for training and/or technical assistance.

Activity 3: Implement the statewide strategic plan to prevent violence against women.

Update: During the Violence Against Women Prevention Advisory Committee (VAWPAC) meeting in Sept. 03, an ad hoc group was formed to make a proposal to the VAWPAC regarding the future leadership and structure of the group. In Jan. 04, leadership of the VAWPAC was transferred to the Texas Association Against Sexual Assault. TDH's role is currently strictly advisory and TDH will monitor implementation of the strategic plan.

In Nov. 03, VAWPAC received a 10,000-dollar grant from Texas Health Resources. The ad hoc group mentioned earlier proposed that the funding be used to hire a grant writer in order to secure additional funding and that that funding, in part, be used to hire an executive director to oversee the implementation of the strategic plan.

### c. Plan for the Coming Year

Activity 1: Distribute family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers.

Output Measure: Number and type of materials distributed; number of entities receiving materials and number of requests for information received.

Monitoring: Track distribution of materials.

Evaluation: Assess the usefulness and effectiveness of the materials by enclosing a questionnaire with the educational materials to be returned to the program at a later time.

Activity 2: Through the program website, continue providing accessible abuse prevention and youth development training to Title V providers, TDH regional offices, and other interested parties.

Output Measure: Training modules developed and accessible to interested parties on the TDH website; number of hits to the training module website; number of participants completing the training by type and region; and number of requests for technical assistance received and provided.

Monitoring: Track the number of hits to the program website on the TDH web page.

Evaluation: Assess the usefulness and effectiveness of the training by evaluating feedback forms from the training website.

Activity 3: Implement the statewide strategic plan to prevent violence against women.

Output Measure: Quarterly reports of Violence Against Women Plan (VWAP) strategic plan implementation activities.

Monitoring: Maintain a log of meetings with the Texas Family Violence Council, TDH Injury Prevention Program and the TDH Center for Health Training; document minutes from meetings; keep track of the major steps of the plan implementation.

Evaluation: Evaluate implementation of the strategic plan based on the priority needs derived from the needs assessment conducted in Spring 2003.

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Change in institutionalized CSHCN, as percent of previous year.				
1. Participate in state-level committees/taskforces to collaborate with many partners to support permanency planning and community living options for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide family support services for CSHCN and their families to enable CSHCN to live with their families in the community.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of children and adolescents (aged 13-19) who chose healthy behavior.				
1. Provide workshops on youth risk reduction and youth health promotion to health care and educational professionals at Texas' regional Education Service Centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide funding to community-based organizations to promote abstinence from sexual activities through a variety of strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Percent of infants and children (aged 0-12) who will thrive.				
1. Develop a statewide Early Childhood System in conjunction with internal and external stakeholders and prepare recommendations for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

inclusion in a comprehensive state plan.				
2. Provide traffic-seat safety presentations to children ages 0-8 regarding car seat safety.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide high quality safety seats and education concerning their use to low-income families through a distribution program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Work with key stakeholders in enlisting broad base support through a grassroots campaign throughout the state.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Ratio of Black low birth weight rate to White low birth weight rate.				
1. Promoting smoking cessation to African American women, including pregnant women by informing providers about smoking cessation programs and distributing information about smoking cessation counseling.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) The prevalence of childhood obesity.				
1. Expand the "Strategic Plan for the Prevention of Obesity in Texas" to be a comprehensive state plan addressing obesity, nutrition and physical activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contract with the University of North Texas Health Science Center to conduct social marketing research to develop messages to use with the implementation of the "Strategic Plan for the Prevention of Obesity in Texas."	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Incidence of carious lesions among school children in Texas.				
1. Conduct statewide survey of caries prevalence among school children in Texas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promote the health benefits of community water fluoridation, maintain existing fluoridation systems, and provide upgrades to existing fluoridation systems at the community level, pending funding availability.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of female clients suspected of being victims of relationship violence.				
1. Distribute family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide, through the program website, accessible abuse prevention and youth development training to Title V providers, TDH regional offices, and other interested parties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Implement the statewide strategic plan to prevent violence against women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## E. OTHER PROGRAM ACTIVITIES

### Toll-Free Hotline

The Family Health Services (previously called "BabyLove") is the statewide toll-free line that provides information on programs in the Associateship for Family Health. 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, pregnant women, parents, child caregivers, school health providers, family health care providers, community leaders, and outreach workers.

Associateship for Family Health programs listing the Family Health Services number include:

Child Wellness Programs

Take Time For Kids Program

Texas Health Steps (formerly EPSDT)

Children With Special Health Care Needs (Chronically Ill and Disabled Children's Program)

Newborn Screening

Program for Amplification for Children of Texas (PACT)

School Health

Nutrition Services for Women, Infants and Children (WIC)

Family Planning

Prenatal Care

Oral Health Services

Related services on which information is generated include:

Medicaid

Medical Transportation

Food Stamps

Temporary Assistance for Needy Families (TANF)

Early Childhood Intervention

Immunizations

Parenting classes

Service providers for the blind and visually impaired (Texas Commission for the Blind)

Service providers for substance abuse (Texas Commission on Alcohol and Drug Abuse)

Service providers for mental illness and mental retardation services (Texas Department of Mental Health and Mental Retardation)

Texas Special Education hotline (includes information on children with disabilities, section 504 of the Rehabilitation Act)

Texas Rehabilitation Commission (job training for persons with disabilities)

Referral to licensed child-care facilities

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 the Family Health Services hotline. As a result, TDH updated the BabyLove database, purchased new I & R software, obtained I & R specialist training and certification for the Family Health Services Manager, and began a process of quality improvement around program data collection, monitoring and evaluation.

//2004/The hotline received 6,425 calls in FY 02 and to date in FY 03 has received 6,160 calls.//2004//

***//2005/ The hotline received 7,187 calls in FY 03 and as of April of FY 04 has received 7,325 calls. An overall increase in the number of calls received in recent years may be due, in part, to issues related to the economy and employment as well as recent changes in Texas' Medicaid and CHIP programs.***

***In FY 04, and in part as mandated by Texas health and human services system transformation (HB 2292), efforts are underway to consolidate this hotline into 2-1-1 Texas. The "2-1-1" is an abbreviated dialing code for free information and referrals to health and human service and community organizations. The purpose of this effort is to reduce the number of toll-free lines, thus, making some savings, and using efficiently the existing 2-1-1 System. Both CSHCN and Title V staff have been involved in the planning that will transition these calls to the 2-1-1 System effective Sept. 04. The goal of this system is to link individuals and families to critical health and human services provided by nonprofit organizations and government agencies in their own community and to promote the national effort to help promote self-sufficiency by making information about services much easier to find. The 2-1-1 operators will be provided scripts including general information on MCH/CSHCN programs but all specific questions on Title V will still be referred to MCH/CSHCN programs.//2005//***

## **F. TECHNICAL ASSISTANCE**

/2004/ Like many states, Texas' economy, population and health needs of that population, continue to evolve. Increasingly the governmental infrastructures that support them are being called upon to work more effectively and efficiently with limited and often decreasing resources. Consideration and fulfillment of Texas' requests for technical assistance, as illustrated on Form 15, will continue and/or enhance existing efforts designed to meet the changes in this dynamic environment, specifically in the area of women's health.

Form 15 provides a preliminary idea of some of the major issues that Texas has identified to receive consultation help and effort during the coming year and for which Texas' requests technical assistance.

Item 1 on Form 15 specifically relates to National Performance Measure 15 - the percent of very low birth weight infants among all live births. Texas requests assistance in identifying low-cost strategies/best practices that other states (or entities) have used to address this issue. Title V could then offer Texas' public health regions and local health departments and/or other entities strategies that could be easily adapted to meet Texas' needs. Technical assistance in identifying the effective and proven strategies employed by other states or entities would be helpful and eventually would be adapted for use in Texas communities.

Item 2 on Form 15 relates to National Performance Measure 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. Again Texas requests assistance in identifying (and perhaps modifying for use in Texas) proven low-cost strategies and best practices in this area used by other states or other entities focused on the same populations. Adaptation of some of those identified strategies for use in Texas would facilitate progress toward increasing the percent of infants born to pregnant women receiving prenatal care.

Item 3 on Form 15 does not relate to any specific measure, but has implications for all of those focused on women's health issues. This technical assistance request seeks expertise in the area of assessment of health status in women. Specifically Texas asks for assistance in developing, implementing and analyzing the results of a statewide assessment of the health status of women of childbearing age. This assessment would then be conducted at a regular interval (i.e., every 5 years). Results of the assessment would be used by internal and external stakeholder and policy and decision makers in meeting the needs of this population and in strategic planning. Currently many stakeholders do not have a complete understanding of how various data pieces interrelate and how such data, when viewed comprehensively, often presents a full assessment of the status of women in the state and ultimately how that assessment can in turn impact perinatal outcomes.

Item 4 on Form 15 again does not relate to a specific measure, but definitely would have an impact on

many maternal and child health programs at TDH. This request repeats a request made last year in the area of social marketing. Specifically Texas Title V requests that a traveling training team from the Annual Social Marketing Conference travel to Texas to present this training for the maternal and child health program staff in Texas as well as interested stakeholders. Effective use of social marketing in the areas of outreach to common populations will have an impact on the health status of our targeted populations. Bringing this renowned training to Texas will facilitate enhanced and common understanding about the benefits and use of social marketing specifically within the framework of public health. Information and collaborations formed as a result of the training and the enhanced knowledge may help both TDH and its stakeholders in leveraging limited funds and enhancing existing and fostering new collaborations.

Item 5 on Form 15 relates to all the CSHCN national and state performance measures. Specifically Texas CSHCN Program requests technical assistance in identifying and implementing best-practices and low-cost effective strategies that other states use to address the needs of CSHCN given ongoing changes and limitations in both state CHIP and Medicaid Programs, as well as best practices in other states on projecting program expenditures and remaining within budget while adjusting to fluctuating health care costs. Receipt of this technical assistance will help Texas, and likely other states, in managing many facets of CSHCN programs in very dynamic and resource challenged environments.//2004//

***//2005/ The dynamic and continuously evolving nature of Texas' economy, population, and the health needs of that population, coupled with the health and human services system transformation referenced throughout this application, provide the ideal environment under which Texas' Title V program makes the technical assistance (TA) requests detailed on Form 15. Continued consideration of some repeat TA requests and consideration and fulfillment of a new request will enhance the state's ability to meet the challenges and opportunities that such a dynamic environment presents.***

***Form 15 lists some of the preliminary areas for which Texas requests technical assistance in FY 05.***

***Item 1 on Form 15 renews a request made last year. This request for technical assistance directly relates to National Performance Measure 15 concerning low birth weight infants. Specifically Texas requests assistance in identifying low-cost strategies/best practices that other states or entities have used to address this issue. With the fulfillment of this TA request Texas Title V staff may be able to adapt strategies to Texas' needs and population and ideally could impact the incidence of low-birth weight infants.***

***Item 2 on Form 15 also renews a request made last year relating to National Performance Measure 18 concerning receipt of early prenatal care. Texas continues to have a need to identify strategies that meet the needs of a diverse, growing population.***

***Item 3 on Form 15, while not relating to a specific measure, if granted would likely have an impact on many of the MCH and CSHCN measures. This repeated request asks for Title V to provide a traveling team from the Univ. of Southern Florida to present a social marketing training similar to the 1 they have presented at the Annual Social Marketing Conference. This training could be offered to Texas and neighboring states' Title V staffs and would provide an opportunity to improve knowledge and potential application of social marketing within the framework of public health activities targeting women, children and CSHCN.***

***Item 4, relates to all the CSHCN national and state performance measures, as well as many other national and state performance measures. As part of the HHS system transformation discussed in detail in other sections of this application, state mental health programs, alcohol and substance abuse programs, and Texas' Title V and CSHCN programs will become part of the same agency in FY 05. This consolidation provides opportunities and challenges in better integration of mental health and substance abuse services with maternal and child health care services. Learning more about how other states or other entities have integrated such services, identifying best practices for such integration and translating those best practices into strategies and initiatives would enhance the overall delivery of such services to Texas' population. //2005//***



## V. BUDGET NARRATIVE

### A. EXPENDITURES

#### FY 04 Application Update

Forms 3, 4, and 5 show variations in the expenditure amounts that could be explained by the budget realignment conducted for FY 02 and the re-directing of Title V funds to accommodate specific MCH population needs.

Form 3 shows a variation in expenditures between FY 01 and FY 02. The expenditure level decreased from \$107,287,294 in FY 01 to \$101,362,842 in FY 02, representing about a \$5.92 million or a 5.5% variation. This is justified, since the total Title V budget was reduced by \$7.8 million in FY 02 in order for Title V to operate within federal and state appropriations.

Form 4 shows a leveled distribution of expenditures across MCH population types, with the exception of children with special health care needs between FY 01 and FY 02. Variations in expenditures for pregnant women, infants less than 1 year old, and children between the ages of 1 and 22 are proportional and these variations are due mainly to the Title V FY 02 budget realignment. Expenditures for CSHCN decreased from \$41,346,111 in FY 01 to \$35,650,770 in FY 02 because to the fact that Title V was asked by the 77th Legislative Session to transfer one-time only \$7 million in Title V funds to the Interagency Council on Early Childhood Intervention (ECI), which provides a coordinated system of services available in every Texas county for children, birth through age 3, with disabilities or delays.

While Form 5 indicates a variation in expenditures of about \$1 million between FY 01 and FY 02 across population-based services, enabling services, and infrastructure building services, direct health care services showed a greater variation in expenditure of \$4.2 million during the same period. The \$1 million reduction in expenditures is due mainly to the FY 02 budget realignment and the direct health care services reduction is due to the transfer of \$7 million to ECI.

#### ***/2005/FY 2005 Update - FY 05 Application Update***

***Forms 3, 4, and 5 show variations in the expenditure amounts that could be explained by the Title V budget realignment conducted for FY 02 and FY 03, directives from recent legislative sessions, and the re-directing of Title V funds to accommodate specific MCH population needs.***

***Form 3 shows a variation in expenditures between FY 01 and FY 03. The expenditure level decreased from \$107,287,294 in FY 01 to \$84,352,152 in FY 03. A portion of this decrease is attributed to a reduction in Title V state funds by an estimated of \$7.8 million and \$4.5 million in FY 02 and FY 03, respectively. This budget re-alignment effort was necessary because the Title V MCH program budgeted for services over and above the annual state and federal appropriations for some time. In addition, the 77th Legislative Session mandated Title V MCH and CSHCN programs to transfer state general revenue funds to CHIP and the Interagency Council on Early Childhood Intervention. More information about these transfers is provided in Form 4: Budget Details by Types of Individuals Served.***

***Form 3 also shows a carryforward of about \$7.9 million from FY 04 into FY 05. A portion of this carryforward could not be used to remove additional children from the CSHCN waiting list since this funding is available only 1 time. In other words, the CSHCN program could not sustain similar capacity to cover expenditures for all these children beyond FY 05. TDH Rider 45, General Appropriations Act, 78th Legislature Regular Session further complicates the use of this carryforward since CSHCN expenditures have to be in proportion to the federal funds appropriated to the CSHCN Strategy. In addition, as required by TDH Rider 45, the change from 12-month continuous eligibility limitations to 6 in order to be consistent with the 6-month continuous eligibility in effect in the Medicaid program may have impacted the level of FY 04***

**expenditures of the CSHCN program rolls. Form 4 shows variations in the expenditures across MCH population types. Pregnant women, as well as infants under 1 year old, remain stable between FY 01 and FY 03. The expenditure levels between FY 01 and FY 03 are \$ 18.1 million and \$17.4 for pregnant women, and \$188,643 and 181,503 for infants under 1 year old. These slight variations in expenditures for pregnant women and infants less than 1 year old can be attributed to the FY 02 & FY 03 Title V budget re-alignment.**

**Expenditures on children between the ages of 1 and 22 vary greatly from \$25,509,699 in FY 02 to \$20,564,187 in FY03. This variation is due mainly to the Title V FY 03 budget realignment in which direct fee-for-service contracts were reduced and the impact of CHIP. Title V-funded contractors are required to screen children for potential Medicaid and CHIP eligibility prior to determining Title V eligibility.**

**Expenditures for CSHCN decreased from \$41,346,111 in FY 01 to \$36,410,932 in FY 02 and to \$26,852,747 in FY 03. This decrease can be attributed to 2 main reasons: 1) Title V was asked by the 77th Legislative Session to transfer 1-time only \$7 million in Title V funds to the Interagency Council on Early Childhood Intervention (ECI), which provides a coordinated system of services available in every Texas county for children, birth through age 3, with disabilities or delays and 2) CSHCN program was mandated by the same legislative session above to commit state general revenues funds of \$3 million in FY 02 and \$10 million in FY 03 as savings acquired due to CSHCN being covered by CHIP and Medicaid programs.**

**Form 5 indicates significant variation in expenditures by types of service. As result of the decrease in total expenditures of \$107,287,294 in FY 01 to \$84,352,152 in FY 03, every category (i.e., direct health care services, enabling services, population-based services, and infrastructure building services) experienced decreases in expenditures. The rationale behind these expenditure variations was addressed in Forms 3 & 4 budget justifications.//2005//**

## **B. BUDGET**

FY 04 Application Update

Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort (MOE) amount of \$40,208,728. This represents \$10 million in excess of the state matching rate of \$3 state dollars for every \$4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement

Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care needs. The Title V program funds accountants within the Associateship For Family Health Financial Monitoring Division (FMD) whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. FMD staff prepare financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a quarterly basis. Title V program leadership reviews reports and provides feedback as needed.

To achieve the 30% - 30% requirement, the Title V contracts program requires all Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount.

For FY 04, Form 2 shows that \$12,185,226 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional \$12,185,226 for children with special care

needs.

The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at \$4,061,742 as shown in Form 2.

#### Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These grants include: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - Oral Health Program; 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 10) Childhood Immunizations - Integrated Public Health Information System.

#### Texas Title V Budget Alignment for the FY 02-03 Biennium

The Texas Legislature allocates Federal Title V block grant funding and state general revenue funding primarily to two strategies within the Texas Department of Health: 1) Maternal and Child Health (MCH) Strategy, and; 2) Children With Special Health Care Needs (CSHCN) Strategy. The Texas Legislature meets once every two years.

For the FY 02-03 biennium, Title V MCH Program initiated a coordinated process to align its budget within existing resources. This budget alignment was necessary because the Title V MCH Program budgeted for services over and above the annual state and federal appropriations for some time. Requests were made for additional state revenue funding for the MCH strategy in the TDH Legislative Appropriations Request for FY 2002 and FY 2003 but they were not funded.

In order to operate within the budget, Title V had to reduce its funded programs and workforce by an estimated of \$7.8 million and \$4.5 million based on the FY 01 and FY 02 budgets and projected expenditures, respectively. While Title V was able to address its \$7.8 million budget reduction without decreasing funding to direct fee-for service contracts for FY 02, fee-for-service contracts and population-based projects were cut by about \$1.2 million and \$0.5 million, respectively in FY 03. Form 5 shows that direct health care services were budgeted at \$75.6 million in FY 01 and at \$61.6 million in FY 03. Similarly, funding for population-based services was diminished by close to one million from FY 01 to FY 03.

#### Texas Title V Budget reductions for the FY 04-05 Biennium

The Texas Department of Health (TDH) was asked by the Governor, Lt. Governor, and House Speaker to reduce its FY 2004-05 budget by 12 percent or approximately \$117 million dollars since it was announced that the state faces a revenue shortfall of nearly \$10 billion. Initially, Title V program was proposed for cut of \$10 million in state appropriations, which represented the surplus over the MOE level. By the end the 78th Texas Legislative Session, in legislative Conference Committee, a decision was made to cut Title V by about \$7 million instead of \$10 million, as a result of pressure from advocacy groups and efforts from the TDH leadership. Nonetheless, during the session, there were many tentative actions to cut further Title V state appropriations but such actions did not materialize because of the requirement that stipulates that states must maintain funds provided for MCH health programs at a level at least equal to the level provided by the states in fiscal year 1989. The Texas level of expenditures for MCH services in 1989 was \$40,208,728.

As expected, Form 3 indicates a significant decrease in state budgeted funds from \$58.1 in FY 01 to \$43.8 in FY04. For FY 04, despite the approximative \$7 million reduction in state appropriations, the Title V client services will not be cut significantly because the program is projecting a carryforward amount of \$4.8 from FY 03 into FY 04, as shown in Form 2. On the other hand, the demand for Title V services will increase in FY 04 and beyond as a result of the Texas Legislature's making several significant changes in CHIP and Medicaid programs in response to Texas' increasingly dire budget crisis. While coverage continues for all currently covered populations and the eligibility levels are maintained at 200% of the FPL, significant changes in CHIP program eligibility and coverage will have

an impact on Title V program. These changes include, but are not limited to: changes in continuous eligibility from 12 to 6 months, reduction by 5% of provider reimbursement rates, exclusion of dental care and other critical services from the current benefit package. Similar changes are facing Medicaid program. Legislators made over 19 significant changes to Medicaid. Among the changes are the establishment of enhanced asset verification and the continuation of coverage for adult pregnant women over 158% of the FPL (currently, pregnant women are covered up to 185% of FPL). All these changes coupled with a sluggish economy will make access to care even harder and result in higher health care costs.

*/2005/*

**B. BUDGET FY 05 Application Update**

**Maintenance of Effort and Continuation Funding**

**Texas will continue to provide the maintenance of effort (MOE) amount of \$40,208,728. This represents more than \$10 million in excess of the state matching rate of \$3 state dollars for every \$4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.**

**30% - 30% Federal Requirement**

**Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. The Title V program funds accountants within the Associateship For Family Health Financial Monitoring Division (FMD) whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. FMD and TDH Contracts Management staff prepare financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a quarterly basis. Title V program leadership reviews reports and provides feedback as needed.**

**To achieve the 30% - 30% requirement, the Title V contracts program requires all Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount. For FY 05, Form 2 shows that \$11,372,639 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional \$11,372,639 for children with special care needs. The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at \$3,790,880 as shown in Form 2.**

**Other Sources of Funding for Women and Children Texas receives other federal, state, and private grants related to women and children. These grants include: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB -- Integrated Comprehensive Women's Health Services; 4) MCHB -- Transitioning Healthy Child Care America; 5) State Early Childhood Comprehensive Systems; 6) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 7) Support State Oral Disease Prevention Program; 8) Texas Cancer Council - regional school health specialists; 9) Title X State Coordinated Family Planning Project; 10) CDC Pregnancy Risk Assessment Monitoring System; 11) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling), 12) Chronic Disease Prevention and Health promotion- Obesity Component; and 13) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement.//2005//**



## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.