



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Texas**

**Application for 2013  
Annual Report for 2011**



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## **I. General Requirements**

### **A. Letter of Transmittal**

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

***An attachment is included in this section. IA - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

As per the Title V Block Grant Guidance expiring January 31, 2015, the appropriate assurances and certifications are being maintained Department of State Health Services central office and are available upon request. Please contact Sam B. Cooper, III, at 512-776-2184 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 January 2012; expires January 31, 2015.

### **E. Public Input**

A key goal in planning all activities related to Texas' FY11 Five-Year Needs Assessment and Block Grant Application was a commitment to include all potential external stakeholders in all stages of the process. To ensure input for the Five-Year Needs Assessment was directly from and inclusive of as many public partners, providers, consumers, and other stakeholders interested and impacted by maternal and child health (MCH) issues as possible, the Department of State Health Services (DSHS) contracted with an outside agency to assist with implementation of an external stakeholder input process. The contractor was tasked with obtaining recommendations for establishing the state priorities for the next five years. The process incorporated a wide variety of methods and venues: community and state-level meetings, group presentations, web-based surveys, facilitated exercises, email communication, newsletter articles, and website information.

Consumers, providers, advocates, stakeholders, and local health administrators were actively recruited to participate in 50 Community Listening Sessions in 19 different locations across the state. Subsequently, a web-based survey was administered to all 439 Community Listening Session participants and later a second web-based survey was administered to participants who indicated an ongoing interest in participating in the stakeholder input process and to state-level partners and advocacy groups. Many of these interested participants also attended a day and a half Stakeholder Summit to determine final recommendations for state-level MCH priorities.

After the ten MCH priority needs were drafted, a Public Forum was held in each of the eight DSHS regional headquarters to share the multi-stage stakeholder input process, how the proposed priorities were developed, and how they will be used in the block grant application. The forums were open to anyone and all participants were given an opportunity to express their opinions. A number of avenues were used to notify the public about the forums. The recruitment for the Public Forums was done using the extensive Title V distribution lists generated at the earlier stages of Needs Assessment stakeholder input gathering process. Flyers and posters were mailed out to the various locations and distribution lists. E-mail notices and reminders were

also sent out to the distribution lists. A toll-free line handled any questions from possible public forum attendees. A website specific to the Five-Year Needs Assessment process also provided information on the public forums.

Also in relation to the Five-Year Needs Assessment, the Children with Special Health Care Needs Service Program (CSHCN SP) obtained input focused on children and youth with special health care needs (CYSHCN) from independent surveys of parents, providers, and Community Resource Coordination Group (CRCG) participants; meetings with key statewide advisory councils/groups and collaborative initiatives; and focus group meetings with families. CSHCN SP staff ensured accessibility to these methods for families by using a written format that could easily be reproduced and distributed without needing to have computer access; by translating the documents into Spanish; and by insuring that the documents were written in plain language at a sixth-grade literacy level. For providers and CRCG participants, surveys were made available in an online format.

A draft of the Five-Year Needs Assessment was posted on the MCH section of the DSHS website in April 2010 prior to finalizing the document. An e-mail announcing the posting and inviting comment and suggestions was sent using the aforementioned stakeholder distribution list. A web-based response tool (Needs Assessment Public Comment Survey) was provided to collect public comment.

In addition to public input efforts more specific to the Five-Year Needs Assessment, DSHS employs a number of methods to obtain input and feedback from the public throughout the year. The bi-annual Community Health Services Contractor Roundtables are a mechanism to obtain valuable information from DSHS contracted direct service providers since they represent a diverse cross-section of Texas communities and provide firsthand experience in service delivery. Moreover, discussion time is allotted during Title V quarterly contractor and regional staff conference calls to share information about best practices and challenges in serving MCH populations.

In the absence of a formal stakeholder advisory organization supported through Title V, DSHS staff regularly convenes and attends formal and informal advisory workgroups, steering committees, councils, task forces, and other groups to address emerging issues and work on collaborative initiatives related to MCH populations throughout the year.

The MCH section of the DSHS website (<http://www.dshs.state.tx.us/mch/default.shtm>) contains regularly updated information about Title V and related programs as well as resource materials for public use. This site is used to post past Title V Block Grant Applications as well as the current and past Five-Year Needs Assessments. The draft FY11 Activity Plans for each of the national and state Title V performance measures were posted for public comment the end of June 2010 with notification of the posting sent via email to the stakeholder distribution list and the FY11 Block Grant Application will be posted after submission using the same notification process.

The stakeholder distribution list will be the basis for ongoing and future communication with partners, families, providers, consumers, and other stakeholders interested and impacted by MCH issues.

/2012/ Public input on issues surrounding MCH/CSHCN continues to be an important component of the Title V program and its operations. DSHS programs regularly convene a variety of formal and informal advisory committees, workgroups, focus groups, or other bodies to address diverse health issues, such as school health, immunizations, health disparities, integration of primary health care with mental health, and medical home. Several Title V program areas also have well-populated email distribution lists that are actively used to share information and solicit feedback relative to program and policy changes. These email distribution lists include health professional associations, advocacy groups, and parents interested in Title V.

A draft of the Texas Title V Activity Plan for FY12 was made available to the public on the DSHS MCH website in May and June, 2011. Once posted, contractors and stakeholders were notified of the posting, however only minimal comments were received. The DSHS website transformation continues to evolve. DSHS expects enhanced future opportunities to seek stakeholder input and public comment throughout the block grant development and review process as the DSHS website transformation is finalized. //2012//

***//2013/ The final version of the FY10 Annual Report and FY12 Application was posted on the Title V MCH website following the review in August 2011. The Title V mailbox is monitored for public comment and inquiry throughout the year. DSHS contractors and other stakeholders are invited to participate in conference calls on a quarterly basis and DSHS staff in all regions of the state participate on local or regional committees or groups that address a range of maternal and child health topics. Feedback is received and encouraged during these quarterly conference calls or via e-mail to the Title V mailbox on all topics related to maternal and child health. //2013//***

## **II. Needs Assessment**

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

In conducting the FY11 Title V Five-Year Needs Assessment, DSHS made considerable efforts to ensure that stakeholder input was direct and inclusive of as many partners, providers, consumers, and other stakeholders interested and impacted by MCH issues as possible. The process incorporated a wide variety of methods and venues to gather input from and establish ongoing communication with stakeholders: community meetings, state-level meetings, group presentations, web-based surveys, facilitated exercises, email communication, newsletter articles, and website information.

The extensive stakeholder input process resulted in a ranked list of 24 recommended need statements. The Needs Assessment Planning Group reviewed the statements in the context of the quantitative data that was gathered and then consolidated them based on similarities of populations, services, or functions. Based on the themes that emerged, the group formulated 10 priority needs for the State of Texas. All three Title V MCH populations are included in the new priorities and aspects of prevention, primary care, and services for CYSHCN have been woven throughout the set. The priorities focus on the areas of:

- Access to care across the life course,
- Mental health and substance abuse,
- CYSHCN transition,
- Dental care,
- Healthy child and adolescent development,
- Essential enabling services,
- CYSHCN community-based systems of care,
- Population-based health promotion and disease prevention,
- Health care provider workforce development and retention, and
- Evidence-based interventions.

Following presentations of the proposed priorities to DSHS Executive Leadership and Health Service Region Leadership, the Title V Director shared the proposed priorities through public forums held in each of the eight regional headquarter cities. Feedback received indicated that the proposed priorities were considered valid and within the potential scope of DSHS and Title V-funded activities.

Due in part to the changes in methodology for conducting the FY11 Five-Year Needs Assessment, the priority needs have changed from those identified in FY06. While there appear to be differences in the two lists, the majority of priorities identified in FY06 are embodied under the new priority statements, even if they are not spelled out specifically. The new priorities are meant to serve as a framework that can be used as a guide for the future. This flexibility will allow DSHS to adapt Title V activities to meet new requirements resulting from actions such as possible state budget reductions and/or federal health care reform. The priority to increase access to dental care is the only priority from FY06 to remain in the current list, primarily because of the consistent stakeholder feedback related to unmet needs in this area.

Specifically for CYSHCN in Texas, the most important needs continue to be family participation, increased community-based services and reduction of congregate care; advancement of medical home services; improved transition services and service system coordination; and targeting services based on data analysis of social, demographic, and condition-specific determinants of

health and quality of life outcomes of CYSHCN.

With the focus on stakeholder input as a guide, DSHS chose to evaluate capacity according to the proposed priorities that resulted from the Needs Assessment process. Using the members of the DSHS Title V Needs Assessment Steering Committee as contact points for each division, an assessment tool was provided to gauge capacity in areas related to funding, staffing, policies, information systems, and partnerships. In addition, divisions were asked to assess the alignment of these proposed priorities with existing division goals.

DSHS capacity to address the priorities and needs of the MCH population in Texas includes challenges in available and sustainable funding, information technology, and untapped public/private/academic partnerships. These challenges will be explored further, and specific activities within the Title V national and state performance measures were developed to strengthen those areas within the context of the department's responsibilities as the public health agency, the potential changes in health care systems, and the state budget over the next five-year period.

/2012/ Throughout the fiscal year 2011, agency staff performed a variety of assessment activities related to the maternal and child health populations. The following brief descriptions are provided with the associated performance measure or health indicator.

WIC / Breastfeeding Survey - Annually, WIC surveys clients to measure attitudes, practices, beliefs, and knowledge pertaining to breastfeeding to gain further insight into barriers to breastfeeding in order to improve programmatic initiatives. In 2010, over 3,200 surveys were completed at over 100 WIC clinics. The most recent report can be found at <http://www.dshs.state.tx.us/wichd/nut/nesurveyresults.shtm>. The Healthy Eating Habits Baseline study conducted for the State Nutrition Action Plan included 12 focus groups with parents, a quantitative phone survey of 1936 parents, 6 focus groups with child care providers, a quantitative phone survey of 714 child care providers, and in-depth interviews with Extension, WIC, and Food bank educators, and state agency stakeholders. The report can be found at <http://www.dshs.state.tx.us/wichd/nut/riskreport-nut.shtm#NETrainingPlans>.

PRAMS Analysis - Annually, approximately 2,400 women are surveyed on their experiences before, during, and after pregnancy as part of Texas' Pregnancy Risk Assessment Monitoring System (PRAMS). Texas PRAMS data are available for years 2002 through 2009; these data have been analyzed for inclusion in presentations to community stakeholders, and in response to data requests from internal and external stakeholders. Additionally, data through year 2007 have been published in the annual data book, which contains findings for approximately 50 critical survey questions and highlights findings for key population subgroups that are at risk for poor pregnancy outcomes. <http://www.dshs.state.tx.us/mch/default.shtm#PRAMS2> //2012//

***/2013/ DSHS staff continued to perform a variety of needs assessment activities related to maternal and child health populations throughout fiscal year 2012.***

***PRAMS -- The annual Pregnancy Risk Assessment Monitoring System (PRAMS) survey was completed by approximately 2,400 women. Texas PRAMS data are now available for the years 2002 through 2010. DSHS also published the 2009 PRAMS data book and can be accessed online at <http://www.dshs.state.tx.us/mch/#PRAMS2>.***

***WIC Nutrition Reports -- The Texas Women, Infant, and Children (WIC) Nutrition Program at DSHS published their FY2011 Nutrition Risk Report to their website at <http://www.dshs.state.tx.us/wichd/nut/riskreport-nut.shtm#Riskreports>.***

***DSHS Contractors -- As part of an ongoing process, Title V Fee-for-Service contractors as well as CSHCN community based contractors participate in agency conference calls and are provided regular opportunities to express feedback to either their specific programs or***

***general questions or concerns regarding maternal and child health populations. As part of their contractual requirements, these contractors must provide all clients served the opportunity to complete an annual satisfaction survey of the services they receive from these contractors. //2013//***

### III. State Overview

#### A. Overview

Successful implementation of Title V activities in Texas depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women, children, and families in the context of their communities. The following description of geographic, demographic, economic, and social trends provides an overview of select characteristics for Texas.

#### LAND AREA

Texas' land area is approximately 262,000 square miles, accounting for 7.4% of the total U.S. land area. The area is equal to the land area of all six New England states, Ohio, New York, Pennsylvania, and North Carolina combined. The longest straight-line distance in a general north-south direction is 801 miles from the northwest corner of the Panhandle to the extreme southern tip of Texas on the Rio Grande below Brownsville. With the large north-south expanse of Texas, Dalhart, in the northwestern corner of the state, is closer to the state capitals of Kansas (~430 miles), Colorado (~310 miles), New Mexico (~200 miles), Oklahoma (~275 miles), and Wyoming (~390 miles) than it is to Austin (~470 miles), its own state capital. The greatest east-west distance is 773 miles from the extreme eastward bend in the Sabine River in Newton County to the extreme western bulge of the Rio Grande just above El Paso. This east-west expanse is so large that El Paso, in the western corner of the state, is closer to San Diego, California (~630 miles) than to Beaumont (~740 miles), near the Louisiana state line; Beaumont, in turn, is closer to Jacksonville, Florida (~680 miles) than it is to El Paso. Finally, Texarkana, in the northeastern corner of the state, is about the same distance from Chicago, Illinois as it is to El Paso (~750 miles). Given the size of Texas, the distance some individuals must travel to receive services is a significant barrier to accessing and receiving those services.

#### METROPOLITAN, MICROPOLITAN, RURAL, AND BORDER COUNTIES

Texas has a mixture of urban, rural, and border populations. According to the Office of the State Demographer, the majority of Texans live in urban areas (91.9%). Of the 254 counties in Texas, 156 are rural, accounting for approximately 8.1% of the 2008 Texas. In addition to urban and rural areas, Texas is one of four states that shares a geographic border with Mexico. As defined in the La Paz Agreement of 1983, the border region includes the area within 100 kilometers (or 62 miles) of the Rio Grande River. By this definition, the Texas border region includes 32 of Texas' 254 counties and 10.2% of the Texas population. Of these 32 counties, four are urban.

The length of the Texas-Mexico border accounts for 45.1% of the 1,969 mile U.S. - Mexico border. The majority of the population along the entire U.S. - Mexico border resides in 14 pairs of U.S. - Mexico sister cities. Seven of the 14 pairs are located in Texas. The sister cities along the U.S. - Mexico border are linked economically, culturally, and environmentally. According to the U.S. Department of Transportation, in 2007, there were 26,274,077 trains, buses, trucks, and personal vehicles and 62,054,088 people who entered the U.S. at Texas border checkpoints.

//2012/ Based on updated 2007 data from the Bureau of Transportation Statistics, U.S. Department of Transportation, there were 45,286,435 trains, buses, trucks, and personal vehicles and 107,147,439 people who entered the U.S. at Texas border checkpoints. However, in 2010, there was approximately a 30% decrease in both the number of vehicles and the number of people who entered the U.S, possibly linked to the economic challenges of the times. //2012//

**//2013/ As per the Bureau of Transportation Statistics, US Department of Transportation, in 2011 the number of vehicles (32,509,466) and people (70,242,948) who entered the U.S. at Texas border checkpoints further decreased from 2010 by approximately 6% and 15%, respectively. //2013//**

Each of these geographic designations presents a unique service delivery challenge. In urban areas, services must meet the demands of a large, concentrated population. Service delivery challenges of rural area residents include the unavailability and inaccessibility of affordable health care, lack of transportation, limited fiscal resources, little or no economic development, and the absence of trained healthcare professionals. While service needs may be similar between those residing in urban and rural areas, cultural norms and values may be different in urban and rural communities requiring outreach strategies uniquely tailored to each community. In the border region, challenges include limited infrastructure, a developed bi-national culture unique to the region, and cross-border utilization of services.

## POPULATION

According to the U.S. Census Bureau, the estimated 2008 Texas population was 24.3 million people, which accounted for 8.0% of the total U.S. population. Texas' population is equivalent to the individual populations of 11 other states combined. Texas is also home to six of the 21 largest cities in the U.S. (Houston -- 4th, San Antonio -- 7th, Dallas -- 9th, Austin -- 16th, Fort Worth -- 19th, and El Paso -- 21st).

/2012/ Per the U.S. Census 2010, the Texas population was over 25.1 million people. Texas' 2010 population is equivalent to the individual populations of 17 other states combined. Texas is now home to six of the largest 19 cities in the U.S. //2012//

Between 1990 and 2008, the Texas population increased 42.5% compared to the overall growth in the U.S. of 22.3%. Between 2000 and 2008, the Texas population increased 16.6% compared to the overall growth in the U.S. of 8.2%. Texas was the seventh fastest growing state between 1990 and 2008 and the sixth fastest growing state between 2000 and 2008. Population growth varies throughout Texas. Areas surrounding three of the state's largest urban areas, Dallas/Fort Worth, Houston, and San Antonio/Austin experienced some of the most significant growth between 2000 and 2008. According to the Texas State Data Center, Texas' population will exceed 25 million people during the year 2010, and by 2040 will reach a population in excess of 43 million people. Between 2000 and 2020, the Texas population is expected to increase by 45.1%.

/2012/ Between 2000 and 2010, the U.S. Census 2010 noted that the Texas population increased 20.6% compared to the overall growth in the U.S. of 9.7%. The Texas State Data Center projects that Texas' population will exceed 28 million during the year 2015 and by 2040 will reach a population nearing 45 million people. (Source: Texas State Data Center, 2009.) //2012//

The Texas State Data Center estimated that 10.2% (2,472,030) of the 24,326,974 Texas residents in 2008 resided along the Texas Border. Of these 2.5 million border residents, 58.0% of them were less than 35 years old, compared to the non-border population, where only 51.8% of them were less than 35. Similarly, urban counties have a younger population. Of the 22,360,411 Texas residents residing in an urban county, 53.0% were less than 35 years old, compared to 45.6% in rural counties.

***/2013/ The Texas State Data Center estimated in 2010 that approximately 10.3% (2,602,102) of the 25,145,561 Texas residents were living along the Texas border. Among the border and non-border Texas residents, 56.4% and 51.4% were less than 35 years of age, respectively. Similarly, among the 22,065,189 (87.8% of total Texas population) Texas residents living in urban counties, 52.7% were less than 35 years age compared to 45.9% of the 3,060,392 Texas residents in rural counties. //2013//***

## POPULATION ALONG THE TEXAS-MEXICO BORDER

Between 1950 and 2000, the U.S. - Mexico border population increased by approximately 10

million people; between 1990 and 2008, the population in the Texas -- Mexico border region increased by 44.9%. Populations along the border have increased significantly over the past 20 years, due in part to the maquiladora program begun in 1965. This program provided economic incentives to foreign (mostly U.S.-owned) assembly factories located in the border region. With about 1,700 factories operating in Mexico in 1990, the rate of industrial development increased further after the North American Free Trade Agreement. By 2001, the 1,700 factories had more than doubled to nearly 3,800 maquiladora factories, 2,700 of which were in Mexican-border states.

The demand for affordable housing in areas along the Texas-Mexico border has contributed to the development of colonias in this region. According to the Texas Secretary of State, colonias are "residential areas along the Texas-Mexico border that may lack some of the most basic living necessities, such as potable water and sewer systems, electricity, paved roads, and safe and sanitary housing." There are approximately 400,000 Texans residing in more than 2,000 existing colonias.

In the coming years, population growth is expected to continue along the Texas-Mexico border. Estimates indicate that between 2008 and 2020, the population in the border region will increase 30.9%. Growth along this region has led to a number of quality of life improvements for residents such as paved streets and access to education. However, this population growth is also a potential burden on the health care system on both sides of the border, which could result in limited health care access and contribute to significant cross-border utilization of services.

#### AGE AND SEX BREAKDOWN IN TEXAS: YOUNG ADULTS AND WOMEN OF CHILDBEARING AGE

The population of Texas is relatively young compared to the rest of the nation. The 2008 estimated Texas median age was 33.2 years, 3.6 years younger than the estimated median age of 36.8 years for the entire U.S. This makes Texas 2nd only to Utah (median age 28.7) as the nation's "youngest" state (including Washington, DC).

The Texas State Data Center estimated the 2008 total female population of Texas at 12,137,007 (49.9% of the overall population). Women of childbearing age (15 to 44 years) comprised 43.5% of the total female population. Between 2000 and 2020 in Texas, the population of women 15 to 44 years of age is expected to increase by 32.5%, an increase of 1.4 million women.

***//2013/ The Texas State Data Center estimated in 2010 that the median age of Texas residents was 33.6 years. Texas is still second only to Utah (median age 29.2 years) which is ranked as the "youngest" state in the US. The total female population in Texas increased slightly since 2008 to 12,673,281 (50.4% of overall population). Women of childbearing ages 15-44 years account for 42% of the total female population. //2013//***

#### RACIAL/ETHNIC COMPOSITION OF TEXAS

In 2008, the estimated Texas population included approximately 11.3 million Non-Hispanic Whites (46.6%), 9.1 million Hispanics (37.5%), and 2.8 million Blacks (11.6%). In 2000, 59.5% of Texans five years old and younger and 56.5% of Texans younger than 20 years of age were non-White. These figures foreshadow the emergence of the changing race/ethnicity composition of Texas. By 2015, the number of Hispanics in Texas is estimated to exceed the number of Whites. By 2020, the number of Whites in Texas is projected to increase by 3.5%, while the number of Hispanics is projected to increase by 108.7% during the same time period. In 2000, Whites accounted for 53.1% of the total population in Texas. It is estimated that they will account for 37.9% by 2020, a 28.6% decrease. Conversely, in 2000, Hispanics accounted for 32.0% of the total population in Texas. It is estimated that they will account for 46.0% by 2020, a 43.8% increase.

***/2013/ Per the 2010 Census, the Texas population is comprised of approximately 11.4 million (45.3%) Non-Hispanic Whites, 9.5 million (37.6%) Hispanics and 3.0 million (11.8%) Blacks. In 2010, 7.7% of Texans were less than 5 years of age and 27.3% were less than 18 years of age. //2013//***

#### CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS IN TEXAS

According to the 2005-2006 National Survey of Children with Special Health Care Needs, 12.6% of children and youth in Texas under age 18 (806,746 children and youth) have special health care needs. Using data from 2007, the Annie E. Casey Foundation estimated the number of children with special health care needs in Texas to be 17.0% or over 1.1 million. According to the Casey Foundation data, Texas is second only to California in the estimated number of CYSHCN.

***/2013/ According to the 2009/10 National Survey of Children with Special Health Care Needs, 13.4% of children and youth in Texas under age 18 (919,876 children and youth) have special health care needs. This was lower than the national average of 15.1%. The survey also reported that CYSHCN account for 11.3% of children 0-17 years of age living in households with incomes 0-99% FPL and 14.4% of children 0-17 years of age living in households with incomes 100-199% FPL. The survey indicated that, nationally, CYSHCN account for about 16% of children 0-17 years of age living in households with incomes 0-99% FPL and 15.4% of children 0-17 years of age living in households with incomes 100-199% FPL. //2013//***

Moreover, Social Security Administration data from December 2008 reported that there were more than 112,875 children under the age of 18 in Texas that were blind or disabled and receiving Supplemental Security Income (SSI) benefits. Texas ranked third behind New York and California as having the greatest number of children receiving SSI.

*/2012/ Data from the Social Security Administration in December 2009, indicated that the number of children under the age of 18 in Texas who were blind or disabled and received SSI benefits increased to more than 120,500. //2012//*

***/2013/ As of December 2010, there were 129,744 children in Texas less than 18 years of age that were blind or disabled received SSI. Texas was ranked as having the highest number of children receiving SSI. //2013//***

When compared to the national average, Texas has a higher percentage of CYSHCN under age 18 living in poverty. According to the 2005-2006 NS-CSHCN almost 17% of Texas CYSHCN under age 18 live in households below 100% of the Federal Poverty Level (FPL), as compared to the national average of 15.7%, and 20.9% of Texas CYSHCN under age 18 live in households between 100 -- 199% FPL, as compared to the national average of 19.1%. In total, approximately 38% of Texas CYSHCN under age 18 live in households with incomes below 200% FPL.

#### POPULATION DENSITY

Considerable variations in population density exist throughout Texas, ranging from densely populated areas evidenced in the 25 metropolitan statistical areas to a rural area that has less than 25 people per square mile. The 10 counties with the greatest population density account for 57% of the Texas population with 13,533,994 inhabitants. Outside of these 10 counties, the average population density is 41 people per square mile. This presents a unique service delivery challenge of ensuring sufficient capacity to meet the demand in the most populated areas while also ensuring adequate access in more sparsely populated areas.

#### POVERTY IN TEXAS

Poverty underlies many health disparities in Texas. Poverty limits access to the "fundamental

building blocks" of health such as adequate housing, good nutrition, and the opportunity to seek health services when needed. Health disparities exist among various demographic groups in Texas, including differences across gender, race/ethnicity, education, income, or geographic location. The population groups with the highest poverty levels often have the poorest health statuses.

According to the 2006 American Community Survey, collected by the U.S. Census Bureau, an estimated 16.9% of individuals and 13.3% of families in Texas lived below the federal poverty level. The percentage of individuals living in poverty differed significantly by county, ranging from 4.9% in Rockwall County to 44.4% in Starr County.

/2012/ The U.S. Census Bureau, 2009 noted the proportion of individuals and families in Texas living below the federal poverty level in 2009 increased to 17.3% and 14.2%, respectively. The percentage of individuals living in poverty ranged from 5.5% in Williamson County to 41.6% in Willacy County. //2012//

***/2013/ The US Census Bureau, 2010, reported that 16.8% of individuals and 13.0% of families lived under the federal poverty level in Texas. Specific county level data is not yet available from the US Census Bureau. //2013//***

More Hispanic and Black individuals lived in poverty (25.7% and 25.4%, respectively) than Whites (14.3%). Females were more likely than males to be living in poverty, 18.6% and 15.2%, respectively. Over 34% of female-headed households (no husband present) lived in poverty. In 2006, the poverty threshold for a family of four was \$20,614.

/2012/ The U.S. Census Bureau, 2009 noted the proportion of female-headed households living in poverty increased to 42.0%. The poverty threshold for a family of four was revised to \$22,050 in 2010. //2012//

***/2013/ Similar to previous years, in 2010, more Hispanic (37%) and Black (32%) Texans had income below poverty level compared to Whites (12%). A greater proportion of females (23%) lived in poverty than men (20%). Among female-headed households, 33.3% had income below poverty level. //2013//***

Over 1.5 million of all Texans aged 18 and younger were living in poverty in 2006 (23.8%), ranging from 6.5% in Collin County to 55.4% in Zavala County. Of the 1.5 million Texan children living in poverty, 513,533 were younger than 5 years old (27.1%) and 977,059 were between the ages of 5 and 17 (21.7%).

/2012/ The U.S. Census Bureau, 2009 noted over 1.6 million of all Texans aged 17 and younger were living in poverty (24.3%), ranging from 8.2% in Collin County to 53.5% in Starr County. Twenty-eight percent of children living in poverty were younger than 5 years old and 24.0% were between the ages of 5 and 17. //2012//

***/2013/ The US Census Bureau reported in 2010 among Texas children 0-17 years of age, 23.8% lived in households with incomes below poverty level. Among children less than 18 years of age, 27.1% of children 0-4 years and 22.1% of children 5-17 years of age were living in households with incomes below poverty level, respectively. Specific county level data is not yet available from the US Census Bureau. //2013//***

In 2006, the median household income in Texas, which varied significantly by county of residence, was \$44,943. Zavala County, at \$18,719, had a median household income that was more than four times lower than the median household income in Rockwall County (\$75,477).

/2012/ Based on data from the Economic Research Service, U.S. Department of Agriculture, 2010, the median household income in Texas in 2009 was \$48,286. Zavala County had a

median household income of \$21,841, more than three times lower than the median household income in Fort Bend County (\$80,548). //2012//

***/2013/ The US Census Bureau reported in 2010 that the median income of households in Texas was \$49,646 and per capita income was \$24,870. Specific county level data is not yet available from the US Census Bureau. //2013//***

## UNEMPLOYMENT IN TEXAS

According to the U.S. Department of Labor, the percentage of individuals who were unemployed in 2008 differed significantly by county, ranging from 2.0% in Hemphill, Reagan, and Sutton Counties to 11.9% in Starr County. There were three other counties whose unemployment rate was greater than 10.0% in 2008: Zavala (10.8%), Presidio, (10.8%), and Maverick (11.0%). As of February 2010, Texas had the 19th lowest unemployment rate (8.2%) in the nation.

/2012/ Based on data from the Economic Research Service, U.S. Department of Agriculture, 2010, the percentage of individuals who were unemployed ranged from 3.2% in Hemphill County to 17.9% in Starr County. From February 2010 to April 2011, Texas' unemployment rate decreased by 2.5%. //2012//

***/2013/ The Bureau of Labor Statistics in 2010 reported that the unemployment rate in Texas was 8.2%, compared to the national rate of 9.6%. Texas was ranked 21st in the lowest unemployment rate in the country. In 2011, the unemployment rate further decreased to 7.9%, compared to the national rate of 8.9%, and Texas ranked 23rd in terms of lowest unemployment rate compared to the other states. In 2011, Hemphill County still had the lowest unemployment rate (2.7%) and Starr County again had the highest unemployment rate (16.9%). A total of 23 counties had unemployment rates above 10% (range 10-17%). //2013//***

## HEALTH DISPARITIES

Prematurity, low birth weight, SIDS, and consequently, perinatal and infant mortality, continue to be disparately high in the Black population compared to the White and Hispanic population in Texas. Racial/ethnic disparities in infant mortality rates are significant; with the rate among Black infants more than double that of White infants since 1998. In 2005, the rate of SIDS among Black infants was nearly three times that of White infants. The percent of Black babies born very low birth weight was approximately 2.5 times that of White and Hispanic babies.

/2012/ Texas Vital Statistics Mortality data indicates that the SIDS rate has been highest among black infants and has changed more across time than the rate among other racial/ethnic groups. There was an 11% increase in the SIDS rate among black infants from 2005 to 2006; however, the rate decreased 22% from 2006 to 2007. //2012//

***/2013/ The 2010 update of the Texas Natality and Mortality data indicated 9.8% of infant deaths were SIDS related, a slight increase since 2009 (9.5%). Among SIDS related infant deaths, 38.5% were White infants, 29.0% were Hispanic infants, and 28.1% were Black infants. In 2010, the rate of SIDS among Black infants (142.2 per 100,000 births) was still twice that of White infants (71.7 per 100,000 births). The rate of SIDS among Black infants increased by 16% from 2007 to 2010. //2013//***

In 2006, the maternal mortality rate in Texas was 17.8 deaths per 100,000 live births, which was 33.8% higher than the national rate of 13.3 deaths per 100,000 live births. The maternal mortality rate for Black women was 3.3 and 4.2 times higher than the rate for White and Hispanic women, respectively.

/2012/ Texas Vital Statistics Mortality data indicates that in 2008, the maternal mortality rate in

Texas was 22.2 deaths per 100,000 live births, a 24.7% increase from the 2006 Texas maternal mortality rate. //2012//

***//2013/ The maternal mortality rate in Texas in 2009 increased to 28.9 per 100,000 live births but decreased to 24.6 in 2010 (15% decrease). These rates are higher (24-29%) than the national rates of 23.2 and 19.0 per 100,000 live births in 2009 and 2010, respectively. //2013//***

Between 2000 and 2008, 34.4% of women of childbearing age, on average, reported that they had no health care coverage. Among women with more than a high school education, the percent who had no health care coverage among Hispanic women was more than double that of White and Black women.

#### UNCOMPENSATED CARE

According to a report released by the Texas Department of State Health Services entitled, Charity Care Charges and Selected Financial Data for Acute Care Texas Hospitals, 2008, there was over \$13 billion dollars of uncompensated care in Texas in 2008. This accounted for 9.2% of the total gross patient revenue. Of this \$13 billion, 44.9% was from bad debt and the remaining 55.1% was for charity care. Between 1999 and 2008, uncompensated care increased by nearly 179% in Texas. In 2008, 33.9% of the uncompensated care was provided by public hospitals, 44.5% was provided by nonprofit hospitals and 21.6% was provided by for-profit hospitals.

***//2013/ In 2010, the DSHS Center for Health Statistics reported that 10% of the total charges billed for care in acute care hospitals was uncompensated care. Uncompensated care charges (bad debt and charity) increased from \$5.5 billion in 2001 to \$17.3 billion. Public, non-profit and for-profit hospitals provided 32.6%, 41.8% and 25.6% of the uncompensated care, respectively. Charity care accounted for 54.9% (\$9.5 billion) of the total uncompensated care. //2013//***

#### ACCESS TO CARE

According to the Texas Office of the State Demographer, there were approximately 1.5 million, or 24%, of the population birth to 17 years of age who were uninsured in 2010. Lack of health insurance coverage is one of the greatest barriers to children accessing health care in Texas and the subsequent lack of proper medical care for children can have serious economic repercussions for Texas.

With 61.5% of Texas counties designated as rural, access to primary and preventive health care services for about 2.0 million rural residents remains at risk. One hundred and nineteen counties (76.3%) of the state's 156 rural counties are designated Primary Care Health Professional Shortage Areas (HPSAs). Because of the lack of available primary care providers, such care is often delivered ineffectively and inefficiently.

Hospital emergency rooms often become clinics, a costly way to provide basic care. Without available primary care, rural residents lack an appropriate entry into the health care systems. The barriers to access to care described above may contribute to women not accessing prenatal care in a timely manner, not remaining in care for the duration of the pregnancy, or missing appointments due to reluctance to travel long distances or inability to pay for services.

Postpartum and inter-conception visits may also be delayed or skipped. After infants are born, well-baby checks and immunization visits may be missed or delayed, as well as other preventive and therapeutic physical and dental health visits for both women and children. When these visits are missed, there are fewer opportunities to observe and address developmental delays or health concerns in children that can ultimately lead to chronic problems or secondary disabilities. Limited access to care may also result in delays in identifying mental health issues during the post partum

period and in obtaining effective treatment by mental health practitioners.

#### DIRECT PATIENT CARE PHYSICIANS

In 2009, there were 39,374 direct patient care physicians in Texas. This number excluded federal and military physicians, residents, and fellows. There were approximately 158 direct patient care physicians per 100,000 people in 2009. Texas continues to see an increase in the number of direct patient care physicians in the state. Ten years ago, there were approximately 152 direct patient care physicians per 100,000 people. Despite these improvements, as of September 2009, 25 of the state's 254 counties had no direct patient care physicians, and 18 counties had only one practitioner.

/2012/ Based on data from the DSHS Center for Health Statistics, the number of direct patient care physicians in Texas increased by 4.6% between 2009 and 2010. There were approximately 162 direct patient care physicians per 100,000 people in 2010. //2012//

***/2013/ Based on data from the DSHS Center for Health Statistics, as of September 2011, there were 42,716 direct care physicians in Texas and 165 direct care physicians per 100,000 people. However, 28 counties had no direct care physicians, and 15 counties had only one practicing physician. //2013//***

A subset of direct patient care physicians, there were 16,830 primary care physicians in Texas in 2009. In 2008, the estimated population for Texas was 24.3 million. Of that, 8.1% of this population was located in 156 rural counties and 91.9% was located in the remaining 98 urban counties. In comparison, 5.9% of practicing primary care physicians were located in rural areas of the state, and 94.1% practiced in urban counties. Similarly, the 2008 estimated population in the border area accounted for 10.2% of the total population; however, only 7.5% of practicing primary care physicians resided in a border county.

/2012/ Based on data from the DSHS Center for Health Statistics, the number of primary care physicians in Texas increased by 4.1% between 2009 and 2010. There were approximately 69 primary care physicians per 100,000 people in 2010. //2012//

***/2013/ In 2010, there were a total of 17,526 practicing primary care physicians in Texas which increased to 17,996 in 2011 (69.5 per 100,000 people). In 2010, of the 25.1 million Texas residents, 10.3% resided in border counties and 6.0% of primary care physicians practiced in those counties. Similarly while 12.2% of the Texas population lived in rural counties, only 10.2% of the primary care physicians practiced in rural counties. //2013//***

Recruiting and retaining physicians in rural or border counties can be challenging. Because physicians' salaries in rural areas are often lower with a potentially higher work load than in urban areas, and fewer educational opportunities exist in rural areas, incentives (such as federal and state loan repayment programs) are used to help attract physicians into rural practice or along the border.

#### CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) -SPECIFIC PROVIDER ISSUES

In 2009, there were 16,830 primary care physicians, and 26 counties did not have a primary care physician. In the area of pediatrics, there were 3,028 licensed pediatricians in Texas in 2009, and 137 counties without a pediatrician. This picture is complicated by the fact that, due to a variety of reasons, many physicians outside major medical centers are reluctant to provide ongoing care for children and youth with complex health care needs.

/2012/ In 2010, the number of primary care physicians in Texas increased to 17,526 and 27 counties did not have a primary care physician based on data from the DSHS Center for Health

Statistics. As of September 2010, there were 3,226 licensed pediatricians in Texas, an increase of 6.5% from 2009. //2012//

Many CYSHCN also require occupational therapy, physical therapy, audiology, and nutritional services. Recent data (2009) indicate shortages in a number of areas:

- There were 6,136 occupational therapists, and 91 counties had no occupational therapists.
- There were 10,016 physical therapists, and 49 counties had no physical therapists.
- There were 943 audiologists, and 182 counties had no audiologists.
- There were 3,930 registered dietitians, and 106 counties had no dietitians.

/2012/ Recent 2010 data from the DSHS Center for Health Statistics, indicate the same shortage areas exist, despite increases in the number of occupational therapists, physical therapists, audiologists, and registered dietitians. The number of counties with no occupational therapists has decreased by 1 and the number of counties with no physical therapists has decreased by 2. //2012//

***/2013/ Although the 2011 data from the DSHS Center for Health Statistics show an increase in primary care physicians to 17,996, 29 counties did not have a primary care physician (2 more counties than the previous year). As of September 2011, there were 3,321 licensed pediatricians in Texas, a 3% increase since 2010, and 138 counties did not have a pediatrician.***

***While, there have been some increases in the number of licensed health care professionals as per the 2011 data from the Texas Center for Health Statistics, there are still shortages in a number of areas:***

- There were 6,800 occupational therapists, and 89 counties had no occupational therapists.***
- There were 11,127 physical therapists, and 45 counties had no physical therapists.***
- There were 985 audiologists and 182 counties had no audiologists.***
- There were 4,218 registered dietitians, and 108 counties had no dietitians. //2013//***

#### HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA)

The combined diversity of Texas' demography and geography creates challenges related to adequate access to health services. Whole or partial counties can be designated as a HPSA by having a shortage of primary medical care, dental, or mental health providers.

Sparsely populated areas experience challenges in recruiting and retaining health professionals. Furthermore, supply shortages are not limited to rural areas. Some inner-city areas include pockets of shortage designation areas where primary care is unavailable as well. Although the number of providers may appear adequate in these areas, access is limited based on non-acceptance of Medicaid or a patient's inability to pay for services. The presence of providers does not necessarily equate to access for all residents.

In 2010, 189 of the 254 counties were recognized as having too few primary care physicians including family practitioners, general practitioners, pediatricians, internists, or obstetrician/gynecologists. Twenty counties (7.9%) were determined to be partial primary medical care HPSAs and 169 counties (66.5%) were whole primary medical care HPSAs. More than 19 million, or 78.4%, Texans reside in counties designated as whole or partial HPSAs. Of the total population living in the 189 county area, 39.3% of residents are Hispanic, with the largest concentrations along the Texas-Mexico border and in South Texas.

***/2013/ As of March 2012, 171 (67.3%) of the 254 counties were recognized as having too few primary care physicians including family practitioners, general practitioners,***

***pediatricians, internists, or obstetrician/gynecologists. Thirty-nine counties (15.4%) were determined to be partial primary medical care HPSAs and 132 counties (52%) were whole primary medical care HPSAs. The change in data from 2010 is due to amended criteria published in the Federal Register, removing pending withdrawal of whole county HPSAs and adding new partial county HPSAs. More than 5.8 million Texans reside in counties designated as whole or partial HPSAs. //2013//***

In 2010, 117 (46.1%) of the 254 counties were recognized as having too few dentists. Eight counties (3.1%) were determined to be partial dental HPSAs and 109 counties (42.9%) were whole dental HPSAs. More than 15 million (62.0%) Texans reside in counties with a whole or partial HPSA designation as dental shortage areas.

***//2013/ As of March 2012, 106 (41.7%) of the 254 counties were recognized as having too few dentists. Fifteen counties (5.9%) were determined to be partial dental HPSAs and 91 counties (35.8%) were whole dental HPSAs. The change in data from 2010 is due to amended criteria published in the Federal Register, removing pending withdrawal of whole county HPSAs and adding new partial county HPSAs. Approximately five (5) million Texans reside in counties with a whole or partial HPSA designation as dental shortage areas. //2013//***

In 2010, 194 (76.4%) of the 254 counties were recognized as having too few mental health providers. Two counties (0.8%) were determined to be partial mental health HPSAs and 192 counties (75.6%) were whole mental health HPSAs. Nearly 14 million (57.2%) Texans reside in counties with a whole or partial HPSA designation as mental health shortage areas.

***//2013/ As of March 2012, 213 (83.9%) of the 254 counties were recognized as having too few mental health providers. Twelve counties (4.7%) were determined to be partial mental health HPSAs and 201 counties (79.1%) were whole mental health HPSAs. The change in data from 2010 is due to amended criteria published in the Federal Register, removing pending withdrawal of whole county HPSAs and adding new partial county HPSAs. Over 8.2 million Texans reside in counties with a whole or partial HPSA designation as mental health shortage areas. //2013//***

#### OTHER SHORTAGE AREAS

In 2010, there were 64 counties in Texas without an acute care hospital. As of January 2010, there were a total of 542 acute care hospitals in Texas. Of these 542, 66.9% were located in a metropolitan area. Nearly 44% of all hospitals (235) had fewer than 50 hospital beds. There were 63 counties with no physician assistants; 43 counties without a dentist; 59 counties without nurse practitioners; 40 counties without social workers; and 203 counties with no nurse midwives.

*//2012/ The DSHS Center for Health Statistics noted as of January 2011, the total number of acute care hospitals in Texas increased to 554 hospitals. Nearly 73% of these hospitals were located in a metropolitan area. As of September 2010, there were 48 counties without a dentist; 54 counties without nurse practitioners; 46 counties without social workers; and 210 counties with no nurse midwives. //2012//*

***//2013/ The DSHS Center for Health Statistics noted as of January 2012, there are a total of 547 acute care hospitals in Texas, with 72.7% of these located in metropolitan areas. As of September 2011, there were 45 counties without a dentist, 52 counties without nurse practitioners, 44 counties without social workers, and 204 counties with no midwives. //2013//***

#### TEXAS TITLE V AGENCY DESCRIPTION

The Department of State Health Services (DSHS), which administers Title V, is the state agency

responsible for oversight and implementation of public health and behavioral health services in Texas. Its mission is "To improve health and well-being in Texas." With an annual budget of \$2.9 billion and a workforce of approximately 12,500, DSHS is the fourth largest of Texas' 178 state agencies. DSHS manages nearly 5,400 client services and administrative contracts and conducts business in 157 locations.

In Texas, Title V operates within the strategic plan framework articulated by Texas State Government; the Health and Human Services Commission (HHSC), the state agency responsible for leading and overseeing the health and human services agencies and ensuring that they function as a system; and DSHS. DSHS operations began September 1, 2004, as a result of the passage of House Bill 2292 during the 78th Texas Legislative Regular Session (2003). This legislation established a clear directive to transform the delivery of health and human services in Texas. The consolidation of 12 agencies into a network of 4 new departments under the leadership of HHSC was designed to improve services, increase efficiency, and enhance accountability among the state's health and human service agencies. DSHS consists of the former Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse, the Texas Health Care Information Council, and the community mental health services and state hospital programs formerly operated by the Texas Department of Mental Health and Mental Retardation. This consolidation presented opportunities to integrate primary health care and behavioral health care in an effort to provide a more holistic approach to service delivery.

DSHS promotes optimal health for individuals and communities through the provision of effective public health services, clinical services, mental health services, and substance abuse services. Responsibilities include coordinating a statewide network of services available through DSHS and its partners, ranging from whole population-based services to individual care. In its efforts to improve health and well-being in Texas, DSHS has the following four priority goals:

- Protect and promote the public's health by decreasing health threats and sources of disease;
- Improve the health of children, women, families and individuals, and enhance the capacity of communities to deliver health care services;
- Promote the recovery of persons with infectious disease, substance abuse and/or mental illness who require specialized treatment; and
- Achieve a maximum level of compliance by regulated entities in order to protect public health and safety.

Title V is an important component in achieving the DSHS mission and priority goals. The following statewide benchmarks relevant to the mission and priority goals are also consistent with Title V requirements and outcome and performance measures:

- Number of children served through the Texas Health Steps Program (Medicaid EPSDT);
- Percentage of Texas children in kindergarten who are completely immunized according to school immunization requirements;
- Infant mortality rate;
- Low birth-weight rate;
- Teen pregnancy rate;
- Percentage of births that are out-of-wedlock;
- Number of women served through Title V prenatal care services;

- Percentage of screened positive newborns who receive timely follow-up after newborn screening;
- Rate of substance abuse and alcoholism among Texans;
- Number of women served through the Texas Breast and Cervical Cancer Program;
- Number of Federally Qualified Health Centers (FQHCs) since the inception of the Texas FQHC Incubator Program; and
- Number of people who receive mental health crisis services at community mental health centers.

#### 1) PREVENT AND PREPARE FOR HEALTH THREATS

DSHS is responsible for improving health and well-being in Texas by implementing programs that decrease health threats and sources of disease and enhance state and local public health systems' resistance to health threats and preparedness for health emergencies. This function includes the prevention of chronic and infectious diseases, including those associated with public health emergencies. The function also includes epidemiological studies and registries designed to provide the state with the basic health care information it needs for policy decisions, to address a particular disease, and to identify cases of disease for program evaluation and research. Within this agency priority goal, Title V has responsibility for:

- a. Community Preparedness -- Title V staff provides support to all agency-wide planning, training, and response to a natural disaster, disease outbreak, biologic attack, or other public health emergency.
- b. Health Promotion and Vital Records -- Title V staff work closely with DSHS programs, such as the Center for Health Statistics, Cancer Registry, and Vital Statistics, that are charged with the collection and provision of health information needed to make state and local policy decisions and to evaluate interventions related to health status improvement. In addition, Title V provides a portion of funding to the Texas Birth Defects Registry to identify and describe the patterns of birth defects in Texas. Tracking this data provides information on the types of birth defects that are occurring, how often and where they occur, and in what populations they are occurring. This information can be used to identify the causes of birth defects, implement effective prevention and intervention strategies, and refer affected children and their families to medical and social services.
- c. Immunizations -- DSHS immunization activities improve quality of life and life expectancy by achieving and maintaining an environment free of vaccine-preventable diseases. Title V staff promote the use of ImmTrac, the statewide immunization registry; educate providers and the public about immunization strategies and their public health value; and work with stakeholders to implement and improve immunization activities. In 2009, Texas was recognized by the CDC as the most improved state in immunization coverage levels, ranking 12th in the nation.
- d. HIV and Sexually Transmitted Disease Services (STD) -- The HIV/STD Program works to increase the number of Texans who know their HIV/STD status, reduce the number of HIV-infected persons who have unmet needs for medical care, and educate individuals about risk of HIV/STD issues. Title V staff support these activities through educating stakeholders and communities as well as ensuring access to services through the development of clinical policies carried out by contracted direct service providers or through referrals.
- e. Health Promotion and Chronic Disease Prevention -- Title V provides staffing and funding resources to several programs that promote health and lower the incidence of chronic disease or other unwanted health conditions. Partnerships focus on educating individuals on healthy life

choices (i.e., physical activity and dietary habits), enhancing infrastructure for school-based health education and direct health care services, and outreach and community engagement to create healthy and safe environments (i.e., injury prevention and youth-focused development).

f. Laboratory Services -- The DSHS public health laboratory provides analytical, reference, research, training, and educational services related to laboratory testing. Title V supports laboratory services such as analytical testing and screening services for children and newborns and diagnostic testing for Title V-funded direct service providers.

g. Regional and Local Public Health Services -- The purpose of the local and regional public health system is to safeguard Texans' health by performing preventive, protective, and regulatory functions and effectively responding in an emergency or disaster. In the absence of local health departments or authorities, DSHS health service regions (HSRs) perform critical functions related to public health and preparedness, as well as working to reduce or eliminate health disparities in the state. Title V provides staffing and funding resources through HSRs to conduct activities such as health education, promotion, and assessment of health disparities; working with communities and local officials to strengthen and maintain the local public health infrastructure; planning for and responding to local public health emergencies such as H1N1 or hurricanes; identifying populations with barriers to health care services; evaluating public health outcomes; and enforcing local and state public health laws. See Attachment III. A. Overview -- DSHS HSR Map for a map of the HSR designations.

## 2) BUILD CAPACITY TO IMPROVE COMMUNITY HEALTH

DSHS seeks to ensure that Texans have access to the most fundamental health services, prevention, and treatment across the state, through contracts with providers. These services include primary health care, mental health care, and substance abuse services. DSHS also works through the Women, Infants, and Children (WIC) program to ensure that good nutrition is accessible to Texans who are younger than five years of age or are women who are pregnant, breastfeeding, or post partum. Finally, DSHS works to build health care capacity in communities by providing technical assistance and limited funding to organizations applying for certifications and to health care providers to assist in repaying educational loans. Within this agency priority goal, Title V has responsibility for:

a. Women's Health Services -- Title V provides funds for a wide range of activities that administer and facilitate the statewide, coordinated delivery of preventive, comprehensive health care services to low-income women. Through a competitive process, contracts are awarded to direct service providers across the state to provide family planning, prenatal care, genetics services, dysplasia services, laboratory services, and case management to high-risk pregnant women.

***//2013/ In FY12, as a result of legislative direction in the General Appropriations Act, House Bill 1, 82nd Legislature, Regular Session, state funds that had been previously identified as Title V MOE (Maintenance of Effort) in the Family Planning strategy were reassigned. //2013//***

b. Children with Special Health Care Needs Services Program (CSHCN SP) -- CSHCN SP, in part financed through Title V funding, supports family-centered, community-based strategies to improve the quality of life for eligible children and their families. The program covers health care benefits for children with extraordinary medical needs, disabilities, and chronic health conditions. Health care benefits include a broad array of medical care and related services. The program contracts with community-based organizations in many parts of the state to provide case management, family support, community resources, and clinical services. The program also provides case management services through DSHS staff based in eight regional offices. Developing and increasing access to a medical home is a key initiative of CSHCN SP. Program staff actively collaborate with consumers, providers, other state agency staff, and interested stakeholders to ensure a system of care is in place to meet the needs of CSHCN.

c. Child and Adolescent Health Services -- Title V funds a wide range of activities that administer and facilitate the statewide, coordinated delivery of preventive, comprehensive health care services to low-income children and adolescents. Through a competitive process, contracts are awarded to direct service providers across the state to provide well- and sick-child visits, dental care, family planning, dysplasia detection, laboratory services, and case management to high-risk infants.

d. Community Capacity Building -- Title V is structurally organized to provide administrative oversight to services that develop and enhance the capacities of community direct service providers. One example is the Federally Qualified Health Center (FQHC) infrastructure grants that assist in the development of new or expanded FQHCs. Another example is the recruitment and retention of health care professionals through a cooperative agreement funding from HRSA. The program focuses on clinics that are located in health professional shortage areas and medically underserved areas. The federal funds also support activities that measure access to health care services and designate these as provider shortage areas and medically underserved communities. Related to professional shortages, the Children's Medicaid Loan Repayment Program, Physician Education Loan Repayment, and Dental Education Loan Repayment programs all provide incentives to physicians and dentists who agree to serve an underserved target population in Texas, and receive loan repayment funds for these services. Also within the administrative oversight of Title V, the Promotora/Community Health Worker (CHW) Training and Certification Program coordinates the training and certification process for becoming a certified promotora/CHW to provide outreach, health education, and referrals to local community members.

/2012/ Unfortunately, funding to continue the loan repayment programs was not included in the budget for the 2012-2013 Biennium. //2012//

e. Population-Based Activities -- Title V supports population-based services, such as screening Texas' children for health needs related to vision and hearing, spinal abnormalities, newborn hearing loss, and newborn diseases. Title V-funded programs also promote adolescent health, breastfeeding, tobacco cessation, car seat safety, safe sleep for infants, and fluoridation of drinking water supplies across Texas. For example, Title V staff developed and funded a new initiative focused on healthy adolescent development, using community-based coalitions across the state. In addition, staff design and distribute outreach materials to educate and train parents, child care providers, and early childhood professionals on health and safety issues. Finally, HSR staff work with stakeholders to address injury prevention, childhood obesity, access to care, and teen pregnancy efforts unique to their respective regions.

f. Infrastructure Building Activities -- Title V supports data collection and dissemination efforts such as child fatality review teams and the Pregnancy Risk Assessment Monitoring System; statewide provider training related to suicide prevention and car safety seats; and collaboration among partners throughout the agency and with external stakeholders on variety of MCH issues. Support is also provided to staff that develop policies and standards for the provision of direct services, monitor for contractor compliance with the established standards, and provide technical assistance to direct service contractors.

***/2013/ Healthy Texas Babies, a new state initiative developed to help Texas communities decrease infant mortality using evidence-based interventions managed by Title V staff, provides population-based activities and infrastructure building activities. Population-based activities include 11 local community coalitions that have implemented evidence-based interventions to reduce the incidence of preterm birth and infant mortality in their communities. Infrastructure building activities include the Expert Panel, comprised of a diverse range of key subject matter experts and stakeholders across Texas, which provide critical input into the development and implementation of key areas to support reductions in infant mortality and preterm birth including, but not limited to life planning tools,***

***fatherhood tools, maternal mortality review, hospital certification, and a toolkit designed to make baby's first year of life as safe and healthy as possible. Additionally, Title V staff developed and presented via the agency's "Grand Rounds" program. (Grand Rounds is a workforce development tool that provides various educational learning opportunities to any interested learner within the HHSC Enterprise and community partners at no cost to the participant.) This presentation provided participants with the skills to recognize the clinical implications of non-medically necessary deliveries by induction or cesarean section at less than 39 weeks gestation. Participants were also taught skills to be able to negotiate with and educate parents who request non-medically necessary deliveries at less than 39 weeks gestation. //2013//***

### 3) PROMOTE RECOVERY FOR PERSONS WITH INFECTIOUS DISEASE, SUBSTANCE ABUSE AND/OR MENTAL ILLNESS

DSHS promotes surveillance, education, epidemiology, consultation, and intervention for persons with infectious disease. DSHS is also responsible for improving the health and well-being of Texans across the life-span through substance abuse prevention, mental health promotion, and behavioral health treatment to persons with mental illness or substance abuse issues. As the state mental health authority, DSHS manages contracts with 38 community mental health centers across Texas. DSHS also provides substance abuse treatments services through community organizations that contract with the state.

Title V efforts regarding this agency goal continue to focus on the integration of mental health and substance abuse services into the primary health care setting. For example, Title V staff have convened a inter-agency workgroup to develop best practice guidelines related to domestic violence, substance abuse, mental health, and perinatal health for a variety of provider settings. The tools will assist providers in identifying and determining need and provide guidance regarding intervention techniques and appropriate referral, if necessary.

### 4) PROTECT CONSUMERS THROUGH LICENSING AND REGULATORY SERVICES

DSHS seeks to protect the health of Texans by ensuring high standards in the following areas: health care facilities, health care-related professions (excluding physicians and nurses), EMS providers and personnel, food and food preparation, pharmaceuticals, medical and radiological devices, and consumer products. This function establishes regulatory standards and policies, conducts compliance and enforcement activities, and licenses, surveys, and inspects providers of health care services.

In relation to this priority goal, Title V funded staff provide administrative oversight to the Community Health Worker/Promotora Training and Certification Program. This program works to enhance the development and implementation of statewide training and certification standards for this paraprofessional workforce in Texas. Additionally, Title V staff are beginning efforts to partner with the DSHS Regulatory Services Division to explore avenues to improve data collected and reported to HRSA concerning the percent of very low birth rate infants delivered at facilities for high-risk deliveries and neonates.

### AGENCY-WIDE CHALLENGES TO CAPACITY

A recent agency-wide internal assessment identified key factors that impact DSHS' capacity to improve the health and well-being of all Texans. These factors are similar to those identified in the FY11 Five-Year Needs Assessment for serving the MCH population and include challenges in available and sustainable funding, information technology, and workforce development.

As a state agency, DSHS' budget and staffing levels are determined by the Texas Legislature. Consequently, DSHS must operate with the resources allocated. DSHS has decreased staffing and spending levels to meet mandated budget reductions, while making every effort to minimize

the impact on services. Economic downturns have led to both an increased demand for services and a simultaneous decrease in the financial resources available to address the increased needs. Population growth and risk behaviors further contribute to an escalating need for services. DSHS is working with other federal, state, and local entities to leverage available resources in order to respond to these growing needs.

DSHS Information Technology is in a state of transition from a largely reactive, silo-based, hardware driven environment to a proactive, service delivery focused and data driven infrastructure. Increased focus is being placed on building capacity in the availability, quality, accessibility, security, and sharing of agency data. The systems currently being re-engineered or remediated all include requirements for web-enabling, standards-based architecture, federal and state rules compliance, and inter-operability for data sharing. Strategic initiatives will include evaluations of business intelligence software, e-discovery software, mobile applications strategies, and the use of field data collection and reporting applications utilizing smart phones. Focus is also being placed on broad adoption of electronic health records and electronic medical records. Heightened requirements for interoperability, exchange, data protection, and security will result in shorter technology refresh cycles as the health care industry evolves in response to recent reform. The DSHS technology infrastructure once perceived as a helpful tool for public health practice in Texas is now essential and required.

Surging population growth, shifting demographic trends, and an aging workforce create challenges in maintaining and developing an efficient, effective, and well-trained workforce who are vital to protecting and improving the health and well-being of Texans. In addition, other potential changes in the labor market could jeopardize the acquisition, development, and retention of a current competent workforce. DSHS must continue to collaborate with institutions of higher education to attract candidates with specialized education and training in public health. Continued efforts must support critical training needs in technical areas to enhance and sustain a skilled staff fully engaged in the operations of the organization. The ability to survive competition in other sectors of the labor market will rest upon comprehensive strategic initiatives and optimizing workforce management resulting in the successful performance of the agency's mission.

These challenges will continue to be explored and activities have been and will be developed to strengthen those areas within the context of DSHS' responsibilities as the public health agency, the potential changes in health care systems, and the state budget over the next five-year period. ***An attachment is included in this section. IIIA - Overview***

## **B. Agency Capacity**

### STATEWIDE SYSTEM OF SERVICES

DSHS' focus on physical and behavioral health provides the agency with a broad range of responsibilities associated with improving the health and well-being of Texans, including the health of all women and infants, children and adolescents, and CYSHCN . This mission is accomplished in partnership with numerous academic, research, and health and human services stakeholders across the nation, within Texas, and along the U.S./Mexico border. Service system partners such as DSHS Health Service Regions (HSRs), DSHS hospitals, Local Mental Health Authorities, Federally Qualified Health Centers (FQHC), local health departments, and contracted community service providers serve an important role in working collaboratively to address existing and future issues faced by the agency. Therefore, DSHS actively promotes communication, coordination, and cooperation with these agencies. Where there is a potential for overlap or duplication of functions, DSHS works with other agencies to define roles and responsibilities, establish agreements, and clarify services and client populations to minimize duplication.

Services to improve community health which are provided by DSHS differ from health services provided by other agencies in that they target prevention; that is, they focus on education,

technical assistance to providers, and preventive services that impact whole families. Rather than focusing exclusively on providing access to a full range of health care services, DSHS programs provide services that are designed to reach populations, not just individuals, and to prevent disease and minimize the need for future medical interventions. DSHS communicates and collaborates closely with other federal, state, and local health and human service agencies, particularly those that serve similar populations.

The statutory governance and organizational structure of DSHS in the state plays a determining role in the way many of these functions are performed. For example, because Texas is a "home-rule" state, the local health officials operate autonomously from, but in partnership with, DSHS. Furthermore, HHS agencies produce a single plan addressing opportunities and challenges shared across system in the "Coordinated Strategic Plan for Health and Human Services." This document ensures coordination between HHS agencies by providing a single, coordinated plan for the statewide delivery of services. The plan for state fiscal years 2009-2013 may found at the following website: [http://www.hhs.state.tx.us/StrategicPlans/HHS09-13/StrategicPlan\\_FY2009\\_2013.pdf](http://www.hhs.state.tx.us/StrategicPlans/HHS09-13/StrategicPlan_FY2009_2013.pdf).

Coordination of statewide services is also achieved through Community Resource Coordination Groups (CRCGs) that organize services for children and youth who have multi-agency needs and require interagency collaboration. HHSC provides state level coordination of CRCGs. Organized by counties, some CRCGs cover several counties to form one multi-county group, while others cover a single-county. CRCGs help people whose needs cannot be met by a single agency. Composed of a variety of public and private agencies in an area, CRCGs provide a way for individuals, families, and service providers to prepare action plans that address complex needs of HHS System consumers. The groups can include representation from the HHS System agencies, the criminal or juvenile justice system, the education system, housing agencies, the workforce system, local service providers, and families.

#### TEXAS STATUTES RELEVANT TO TITLE V

Select Texas statutes pertaining to the provision of services to MCH populations includes:

Services to CYSHCN -- CSHCN SP is authorized under Texas Health and Safety Code SS35.001--35.013 which states that the program shall provide 1) early identification; 2) diagnosis and evaluation; 3) rehabilitation services; 4) development and improvement of standards and services; 5) case management services; 6) other family support services; and 7) access to health benefits plan coverage. CSHCN SP rules expand on the details of the above services.

Newborn Screening -- The Texas Legislature first passed legislation in 1965 establishing the Newborn Screening Program. The law requires that all newborns who have been screened and found to be presumptively positive for heritable diseases receive follow-up. Since initial passage, subsequent legislation has revised the program to increase the number of disorders screened to the current total of 28. Cystic Fibrosis was most recently added to the screening panel in December 2009.

Newborn Hearing Screening Program -- Established in 1999 through the passage of House Bill 714, the program is currently being implemented in Texas hospitals offering obstetrical services. DSHS is the oversight agency identified in Chapter 47 of the Health and Safety Code. The purpose is to ensure all children who have hearing loss as newborn infants or young children are identified early and provided appropriate intervention services needed to prevent delays in communication and cognitive skill development.

Birth Defects Monitoring -- In 1993, the Texas Legislature established the Birth Defects Epidemiology and Surveillance program for the purpose of identifying, investigating, and monitoring birth defects cases in Texas. The program is required to provide information to identify the risk factors and causes of birth defects, support the development of strategies to prevent birth

defects, and maintain data in a central registry.

Immunizations -- Also in 1993, a childhood immunization law was passed to mandate age-appropriate immunization of every child in Texas. Exclusions from compliance are allowable on an individual basis for medical contraindications, reasons of conscience, including a religious belief, and active duty in the U.S. Armed Forces.

Sudden Infant Death Syndrome (SIDS) -- Texas law requires that the death of a child 12 months old or younger be reported to the Justice of the Peace, medical examiner, or other proper official if the child dies suddenly or is found dead and the cause is unknown. If SIDS is determined as the cause of death, the law directs DSHS to reimburse the county a fixed sum for the cost of the autopsy.

Child Fatality Review -- Child Fatality Review Teams (CFRT) are authorized under Texas Family Code SS264.501-264.515. The State Committee is a multi-disciplinary group of professionals selected from across the state with a membership reflecting the geographical, cultural, racial, and ethnic diversity of the state that works to understand the causes and incidence of child deaths in Texas; identify procedures within the representative agencies to reduce the number of preventable child deaths; and increase public awareness and make recommendations to the governor and legislature for effective changes in law, policy, and practices.

Child Passenger Safety -- Recent legislation requires children younger than 8 years old, unless they are 4 feet 9 inches in height, to be properly restrained in a child passenger safety seat while riding in an operating vehicle.

Public Education Resources -- Various statutes direct DSHS to develop informational and educational materials on topics including, but not limited to, shaken baby syndrome, perinatal depression, newborn screening, immunizations, safe sleep, teen pregnancy, umbilical cord blood banking and donation, lead poisoning, and injury prevention.

//2012/ The 82nd Legislature, Regular Session, met from January -- May, 2011 and the 1st Called Session met in June 2011. The attached table summarizes key maternal and child health legislation. //2012//

## DSHS TITLE V CAPACITY

### A. Overview of Programs and Services

Title V staff and funding resources are a key element in DSHS' capacity to provide primary and preventive care to the Texas MCH population. Program activities typically include systems development, infrastructure, contract development and support, policy and procedure development, technical assistance, training, and quality assurance to local community organizations working to improve the health of the MCH population.

Please see a full description of agency capacity as it appears in the FY11 Five-Year Needs Assessment.

#### 1) Services for Women, Infants, Children, and Adolescents

The majority of Title V services are provided through contracts with local providers including city/county health departments, hospital districts, school districts, FQHCs, non-profit agencies, and individual providers. Contracts are awarded through a competitive request for proposal process that typically includes a three- to five-year renewal period after the first year of implementation. Many of these providers also contract with DSHS for the provision of other services such as WIC, Title X and/or XX family planning, breast and cervical cancer screening/diagnosis, Texas Health Steps (EPSDT), and HIV/STD.

Direct and enabling health care services are provided to women, children, and families who are not eligible for the same services through other programs such as Medicaid and CHIP and who are at or below 185% FPL. Title V-funded providers are required to screen for Medicaid/CHIP eligibility and to assist those individuals who are potentially eligible with the Medicaid/CHIP application forms. To ensure continuity of care during and after the eligibility determination process, Title V-funded providers must also be enrolled as Medicaid providers. Typically, Title V reimburses contractors for services provided using Medicaid reimbursement rates. If a client that received services paid with Title V funds is later found to be Medicaid/CHIP eligible through the eligibility determination process, contracted providers are able to recoup payment from Medicaid/CHIP for those services and restore funding to Title V.

The majority of laboratory testing services for Title V clients are completed through DSHS laboratory facilities. Otherwise, contractors are reimbursed by Title V using standard rates if testing is completed on-site or by a private laboratory.

Title V-funded staff participate in monitoring, onsite reviews, and quality improvement activities of contracted service providers with respect to MCH services, standards, and regulations.

Preventive and primary care services for women, pregnant women, and infants include:

Prenatal Services -- In coordination with CHIP Perinatal, includes up to two initial visits; ultrasound; nutrition education; laboratory testing; and high-risk case management.

Family Planning Services -- Comprehensive health history and physical exam; laboratory testing such as screenings for cervical cancer, sexually transmitted infections, cholesterol, blood glucose, and pregnancy; provision of contraceptive methods, counseling, and education; treatment of sexually transmitted infections.

***//2013/ In FY12, as a result of legislative direction in the General Appropriations Act, House Bill 1, 82nd Legislature, Regular Session, state funds that had been previously identified as Title V MOE (Maintenance of Effort) in the Family Planning strategy were reassigned. //2013//***

Dysplasia Services -- Initial and follow-up visits; diagnostic and therapeutic procedures such as colposcopy, biopsy, cryotherapy, and LEEP.

Genetics Services -- Detailed family genetic health history; physical examination; laboratory testing; and counseling and case management.

Well-Child Services -- Well and sick child initial and return visits; immunizations; nutritional counseling; and high-risk case management.

Newborn Screening -- Testing for 28 disorders; follow-up and case management to ensure abnormal results receive confirmatory testing and treatment, if needed.

Newborn Hearing Screening -- Testing for hearing impairment; follow-up, diagnostic evaluation, and linkage to intervention services, if needed.

Breastfeeding Support -- Initiatives that promote, support, and educate on the benefits of breastfeeding including a Mother Friendly Worksite designation for businesses that have a written policy that supports breastfeeding employees and customers, Texas Ten Steps Facility designation for hospitals that support breastfeeding in new mothers delivering at the facility, and support for mother-to-mother drop-in centers in local communities for breastfeeding women.

Healthy Start Collaborative -- Support for population-based activities conducted in six Healthy

Start sites in Texas focused on immunizations, breastfeeding, diabetes, folic acid promotion, early prenatal care, and child safety.

Rape Prevention and Education -- Collaborative efforts to support the primary prevention of sexual assault and/or violence through public education and professional development.

***/2013/ Healthy Texas Babies Initiative -- Population-based and infrastructure building activities to reduce infant mortality at community and statewide levels. //2013//***

Preventive and primary care services for children and adolescents include:

Child Health and Dental Services -- Includes well-child, limited acute care, and follow-up visits; immunizations; nutritional counseling; laboratory testing; periodic oral evaluation, fluoride treatments, sealants, and extractions; and high-risk case management.

Texas Health Steps -- Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) providing comprehensive medical and dental prevention, treatment, and case management for Medicaid-eligible children from birth through age 20.

Vision and Hearing Screening -- Annual screening for children 4 years of age through 9th grade who are enrolled in a licensed child care facility, group day care home, or public/private school.

Spinal Screening -- Screening for abnormal spinal curves for 6th and 9th grade students attending public/private school.

Lead Screening -- Screening for elevated blood lead levels for children younger than 15 years of age.

School Health Program -- Development of comprehensive school health education and school-related health care services statewide through a school health network and school-based health centers.

On-line Training Modules -- Web-based, no-cost training to child care providers on a variety of child health issues such as safe sleep, infection control, injury prevention, nutrition, and physical activity.

Obesity Prevention -- Collaborative efforts that support community-based initiatives addressing physical activity and nutrition; a tool kit for school nurses (Get Fit Kit) to use with adolescents identified as overweight or obese through the state's physical assessment test.

Texas Healthy Adolescent Initiative -- Support for local communities to address adolescent health through an evidence-based comprehensive youth development approach.

Oral Health -- Provision of direct preventive dental services to targeted populations through 5 regionally-based dental teams; promotion and monitoring of water fluoridation in the state.

State Child Fatality Review -- Provides assistance, direction, and coordination to investigations of child deaths; identifies local child safety issues; makes recommendations on changes to law, policy, or practice to promote child safety.

DSHS Title V Population-Based Regional Staff -- Conduct regional population-based activities focused on four priority areas: obesity, access to care, injury prevention, and teen pregnancy; participate on local CFRTs.

/2012/ DSHS regional staff continue to plan and implement population-based activities to address national and state performance measures related to teen pregnancy, child motor vehicle safety,

oral health, breastfeeding, children's healthcare coverage, smoking cessation for pregnant women, youth suicide prevention, prenatal care and feto-infant mortality, obesity among school-age children, and preventable child deaths.

Title V provided funding for key one-time projects in FY11 to support key projects supporting MCH populations, including child motor vehicle safety activities and training, medications for HIV positive minority women, improvements to the Birth Defects Registry, immunization campaign and evaluation, suicide prevention and early childhood mental health training, substance abuse specialized training and development of community partnerships. //2012//

Infrastructure building activities that support systems capacity for all MCH populations include:

Leadership Education in Adolescent Health (LEAH) -- Partnership to provide interdisciplinary leadership training, faculty development, continuing education, and technical assistance to develop workforce capacity around MCH health issues.

Promotora/Community Health Worker Training and Certification Program -- Provides leadership to enhance the development and implementation of statewide training and certification standards and administrative rules for the provision of outreach, health education, and referrals by this group of community-based paraprofessionals.

/2012/ The 2011-2016 Texas State Health Plan noted the need to increase the number of certified community health workers in Texas to assist individuals in underserved and rural areas in gaining access to care. Texas is one of the few states that provide certification for community health workers. The number of certified community health workers increased significantly in calendar year 2010 due to increased access to training opportunities. As of December 31, 2010, there were over 1,150 certified community health workers in Texas. DSHS implemented revised rules for the Community Health Worker Training and Certification Program in October 2010 to improve the ability of community health worker or promotores to obtain training and certification. DSHS leadership identified the promotion of a community-based, patient-centered approach to address health and well-being throughout the state as a priority initiative for fiscal year 2010. A workgroup, composed of representatives of divisions and areas throughout the agency, identified current initiatives, reviewed research, and conducted an environmental scan to gain further information about the community-based workforce that includes community health workers. The workgroup provided recommendations to DSHS leadership related to continuing to explore opportunities to promote, fund, and evaluate community health worker models in the delivery of integrated services. HB2610, 82nd Legislature, Regular Session directed DSHS, in conjunction with HHSC, to conduct a study to explore and provide recommendations related to the employment of community health workers and methods of funding and reimbursing community health workers for the provision of healthcare services. //2012//

***/2013/ The number of certified community health workers continued to increase in calendar year 2011. As of December 31, 2011, there were over 1,580 certified community health workers in Texas. DSHS, in conjunction with HHSC, implemented a study to explore and provide recommendations to the Legislature related to the employment of community health workers and methods of funding and reimbursing community health workers for the provision of health care services. //2013//***

Office of Academic Linkages -- Identifies as supports partnerships between DSHS and academic institutions; helps to develop the statewide health-related workforce through continuing education opportunities, grand rounds presentations, residency training program, and nursing leadership coordination.

Centers for Program Coordination, Policy, and Innovation -- Supports agency-wide issues and service integration related to policy analysis and assessment; process improvement; project management; coordination with Medicaid; and rule process coordination.

Office of Border Health -- Works to enhance efforts to promote and protect the health of border residents by reducing community and environmental health hazards along the Texas-Mexico border.

HHSC Office of Elimination of Health Disparities -- Provides technical assistance to HHS agencies to ensure that health disparities are addressed in services provided to increase capacity for improving health status; provides internal and external leadership via collaborative development of health policies and programs that will eliminate health disparities; and promotes cultural competency, research, health literacy and evaluation of health promotion and disease prevention program activities.

***/2013/ The HHSC Office of Elimination of Health Disparities was renamed in FY12 and is now the HHSC Center for Elimination of Disproportionality and Disparities. //2013//***

Data Collection and Surveillance -- Data collection, research, and evaluation support for Title V activities; a number of surveys/systems are used to collect MCH data: Pregnancy Risk Assessment Monitoring System, Texas Infant Sleep Study, WIC Infant Feeding Practices Survey, School Physical Activity and Nutrition Survey, State Systems Development Initiative, Birth Defects Monitoring, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Cancer Registry, and Vital Statistics.

*/2012/ The Center for Program Coordination and Health Policy convened a Health Care Redesign Team, including representation from Family and Community Health Services, Mental Health and Substance Abuse, Prevention and Preparedness, Regional and Local Health Services, Regulatory, Health Information Technology, Legal, Financial, and the Center for Communication and External Affairs. The team will focus on key health care redesign and coordination issues within DSHS. //2012//*

*/2012/ In January 2011, a multidisciplinary panel of over 40 maternal and child health experts convened in Austin, Texas to provide advice, recommendations, and support to the Healthy Texas Babies (HTB) initiative sponsored by the DSHS. In addition, over 20 subject matter experts from DSHS and other Texas Health and Human Services agencies, leadership from the state and national offices of the March of Dimes, and three state and national experts attended the two-day meeting to support the effort. The purpose of the HTB expert panel meeting was to begin development of a coordinated plan to reduce infant mortality in Texas.*

DSHS facilitated the formation of work groups to focus on data, evaluation and research methodologies; intervention strategies; systems identification and development; and communications planning and implementation to continue to develop a coordinated plan. The HTB expert panel will meet again in summer 2011 to review and approve the recommendations to reduce infant mortality in Texas.

A series of meetings across Texas in late summer 2011 will bring together community stakeholders to engage promotores or community health workers, community organizations, and providers in efforts to improve birth outcomes. Title V funded a position to focus on support of the agency's HTB Initiative. Aisling McGuckin, RN, MSN, MPH, joined the Office of Title V and Family Health in April 2011. Ms. McGuckin holds both a Bachelor of Science and a Master of Science in Nursing and a Master of Public Health from Johns Hopkins University in Maryland. She has extensive experience in a variety of public health programs that serve women and children.  
*//2012//*

## 2) Services for CYSHCN

DSHS and other HHS agencies provide a broad range of supports for CYSHCN and their families. The newly formed statewide Task Force for Children with Special Needs will further

define available community services and supports to develop a strategic plan to improve care for CYSHCN and their families.

***/2013/ The Task Force for Children with Special Needs released its Five-Year Strategic Plan in October 2011. Included in the plan were seven major goal areas: organized and reliable information, prevention and early identification, entry points into services, comprehensive array of services and supports, services and supports for transition into adulthood, interagency coordination and collaboration, and strengthened workforce. //2013//***

Despite the opportunity to address improvement in services, state funding limitations have the potential to impact communities. As an example, the Department of Assistive and Rehabilitative Services (DARS) Early Childhood Intervention (ECI) program announced that services may be reduced. Information gathered from statewide stakeholder meetings by DARS will help legislators as they consider the agency's ECI funding request.

***/2013/ The 82nd legislature reduced DARS' funding appropriation for ECI services for fiscal years 2012 and 2013. As a result, DARS narrowed eligibility criteria for the ECI program effective September 1, 2011. //2013//***

Title V federal and state funds support the efforts of CSHCN SP. The program uses a competitive bid process to fund 25 community-based services contractors who provide case management, family supports and community resources, and clinical supports to CYSHCN and their families.

***/2013/ The CSHCN SP funded 23 community-based services contractors in FY12. //2013//***

Title V funded CSHCN SP initiatives include collaboration with the Leadership Education in Adolescent Health (LEAH) project at Baylor College of Medicine to advance and improve transition services, an analysis of Permanency Plans for youth in congregate care by EveryChild, Inc., seed money grants of up to \$20,000 for practices to improve medical home services, and support for the Texas Medical Home Initiative pilot project.

***/2013/ The Title V funded initiative with EveryChild, Inc. analyzing permanency plans for youth in congregate care concluded on August 31, 2011. EveryChild, Inc. provided input to the Task Force on Children with Special Needs based on findings from its study of permanency planning and review of promising practices in other states. Grant projects to improve medical home supports also concluded. One medical home supports contractor, Dell Children's Medical Center, continued their effort initiated with CSHCN SP seed money and began developing plans for a medical home pilot clinic. CSHCN SP funding helped in surveying their community and identifying the need. A second medical home supports contractor, Trinity Mother Frances Hospital, established a National Committee for Quality Assurance (NCQA) recognized patient-centered medical home in all of their primary clinics. //2013//***

CSHCN SP's health care benefits help numerous CYSHCN from communities throughout Texas access health care. In FY09, the program provided health care benefits to 2,377 clients. Health care benefits include family support services, such as respite and home and vehicle modifications. There is a waiting list for the program's health care benefits. However, the program provides case management services through HSR staff and contractors for all clients, including those on the waiting list for health care benefits.

***/2013/ The CSHCN SP provided health care benefits to 1,872 clients in FY11. In the spring of 2012, the program had enough funds to provide time limited health care benefits to all clients (a total of 727 clients) on the waiting list as of March 1, 2012. An additional 222 clients on the waiting list were given time limited benefits starting June 1, 2012. All time limited benefits ended on August 31, 2012. //2013//***

Much of the coordination of health services with other services at the community level is supported through the infrastructure of the CRCGs and DSHS HSR and contractor case management staff. However, community-based services organizations are the true core infrastructure operating in the state. State staff partner with some of these organizations through formal contractual arrangements, electronic mailing list communications, participation in organizational meetings, and participation/presentations at conferences, etc.

Texas Parent to Parent (TxP2P) is the federally-funded Family-to-Family Health Care Education and Information Center. CSHCN SP contracts with TxP2P to provide family support and community services in Harlingen and Dallas. CSHCN SP staff participate in annual parent conferences as speakers, planners, and exhibitors. TxP2P participates in the Medical Home Work Group (MHWG) and provides medical home trainings to professionals and parents throughout the state. Their electronic mailing list communications enable information to be shared with families across Texas.

TxP2P and the other community-based services contractors were instrumental in generating parent input in the Title V CYSHCN Five-Year Needs Assessment process. CSHCN SP staff has collaborated with Texas Education Agency, Education Service Centers, DARS, and Independent Living Centers to promote and improve transition services for CYSHCN in Texas. Staff has taught health transition curricula in the Independent Living Center classroom settings. New partnerships in the areas of education, employment, and adult living are emerging through the collaboration of CSHCN SP staff with other state agency and local organization staff.

The 2-1-1 Texas system improves access and coordination of community-based services and allows callers to find out about health care and other services in their local areas. 2-1-1 serves a vital role in the emergency/ disaster evacuation and planning activities for people with disabilities. CSHCN SP promoted emergency planning and preparedness through the program's bilingual Family Newsletter and Provider Bulletins. Program staff prepared a Spanish language translation of the American Academy of Pediatrics Emergency Information Form (EIF), incorporating commonly used regional idioms. The program encourages community-based services contractors to promote use of the EIF among families of CYSHCN and requires that all practices receiving medical home supports seed money grants increase the numbers of CYSHCN in their practices who have completed the EIF.

Family Voices representatives in Texas are key advocates and spokespersons for improving access to and coordination of health and other services for CYSHCN and their families at the local, regional, state, and national levels. CSHCN SP collaborates with each of these individuals and their projects as well as other parents of CYSHCN and benefits from their expertise and guidance. All participate in the MHWG and all are active in providing community-based services to CYSHCN and their families.

a. Rehabilitation services for CYSHCN receiving SSI

CSHCN SP provides outreach to SSI eligible clients to determine need for case management services. SSI-eligible children in Texas receive Medicaid coverage, providing health care benefits. CSHCN SP provides back-up, gap-filling health benefits coverage if a child receiving SSI loses those benefits due to an extra pay period that causes the family to exceed the SSI income limitations in a single month. Community-based contractors and DSHS case management staff may assist CYSHCN in applying for SSI benefits.

CSHCN SP actively seeks to engage stakeholders in the decision-making process. The program has strengthened ties with the TxP2P organization and collaborates with their efforts to educate parents and caregivers. CSHCN SP funded TxP2P's expansion of services, which includes three distinct geographic areas of Texas. Parents of CYSHCN in various geographic locations have become Family Voices representatives to improve statewide involvement of families in systems development. DSHS regional social work staff and the program's community-based service

contractors work to facilitate family access to services, promote family networking, increase family involvement in community service system development decisions, and obtain family feedback.

b. Family-centered, community-based, coordinated care for CYSHCN

CSHCN SP's community contractors provide health care benefits that include a broad array of services that support children and their families.

CSHCN SP will continue to provide leadership in coordinating development and promotion of medical homes through the MHWG whose membership includes representatives from state agencies, family members, advocates, and private providers. The MHWG meets quarterly to report on efforts of agencies and groups and to continue work on the strategic plan to educate providers and families and promote the development of medical homes.

CSHCN SP collaborates with the Medicaid (Title XIX), and CHIP (Title XXI) programs by providing "gap-filling" services as needed for CYSHCN. As noted above, some children lose Medicaid eligibility certain months due to income, in which case the CSHCN Services Program may be able to provide health care benefits.

B. Culturally Competent Care

Health disparities exist among various demographic groups in Texas, including differences across gender, race/ethnicity, education, income, or geographic location. For example, health disparities between Texans living along the border with Mexico and those in non-border communities have long been a concern for public health.

Activities funded by Title V include an expectation that all staff have a working knowledge of cultural competence and the ability to conduct their work in a manner that shows consideration for racial and ethnic differences and for clients with physical, emotional, and mental disabilities. DSHS works to ensure cultural competence from its contractors through contract assurances, training, and quality assurance monitoring. Title V Request for Proposals (RFPs) include a set of assurances and certifications towards limited English proficiency, interpreter services, and non-discrimination with which each contractor agrees to abide. Morbidity, mortality, and population-in-need data is used to determine regional funding allocation for direct service programs to ensure resources are available to the areas of the state most in need.

Most educational materials for children and women are published or made available in at least English and Spanish, and frequently in other languages based on need. Referral information provided through 2-1-1 Texas is provided 24 hours a day, 7 days a week in multiple languages. In many cases, there are Spanish speaking operators. For the other languages, 2-1-1 Texas contracts with either Tele-Interpreter or the AT&T Language Line. Services are also available through text telephone or TTY for people with hearing impairments.

CSHCN SP proactively works to ensure cultural competence. Bilingual (English and Spanish) and bicultural program staff operate a toll-free line for use by persons applying for and/or receiving the program's health care benefits. In addition, regional case management and eligibility staff are bilingual. Regional offices also use Language Line Services to assist with communication in multiple languages other than English and Spanish. The FY09 Medical Home Support grants strengthened infrastructure and enhanced use of translation programs for clinics.

The program's written communications with its clientele always are done in both English and in Spanish; the program's Web site is available in both English and Spanish; and the program also has many educational materials published in Spanish. CSHCN SP staff works to ensure that contractors are able to communicate with clients in languages other than English. The CSHCN SP Family Newsletter is published in English and Spanish and, in FY09, included an article on respectful language, modern terminology, e.g. "intellectual disabilities".

The 82nd Legislature passed House Bill 1481 requiring all Health and Human Services agencies to use preferred person first respectful language when proposing, adopting, or amending rules, reference materials, publications, and electronic media. Implementation of the bill is meant to establish preferred terms and phrases for new and revised state policy using language that places the person before the disability.

In its ongoing efforts toward cultural competency, CSHCN SP continues to seek opportunities to include input from statewide and regional groups and committees with family members who are both bicultural and bilingual. As discussed earlier, the CSHCN SP family needs assessment surveys were prepared in both English and Spanish. The program's service contractors are grassroots organizations serving communities throughout Texas and their leadership and advisory groups reflect the cultural make-up of the populations they serve, and their consumer satisfaction surveys are bilingual. CSHCN SP staff present at and attend multicultural events to include the Annual African-American Family Support Conference and Annual Symposium of the Texas Association of Healthcare Interpreters and Translators.

CSHCN SP staff partnered with Texas Health Steps to update the Cultural Competency online training module and developed activity plan output measures that require CSHCN SP staff and contractors to complete the training module. The new activity plan reads: to "enhance and promote the use of People First language and use of appropriate languages, literacy levels and cultural approaches in all communications with CSHCN and their families".

Since FY09, all CSHCN SP central office staff and program contractors were required to complete the Cultural Competency training module and has attained a 100% completion rate.

### **C. Organizational Structure**

Please refer to Attachment III. C. Organizational Structure for agency organizational charts effective June 2010.

***//2013/ Please refer to Attachment III. C. Organizational Structure for agency organizational charts effective June 2012. //2013//***

Texas has a plural executive branch system with power divided among the governor and independently elected Executive Branch officeholders. Except for the Secretary of State, all executive officers are elected independently, making them directly answerable to the public rather than the governor.

The Texas Legislature has a House of Representatives with 150 members, while the Senate has 31 members. The Speaker of the House leads the House and the Lieutenant Governor leads the Senate. The Legislature meets in regular session once every two years (odd-numbered years).

During the interim, the Legislative Budget Board (LBB) is one of several statutory bodies that provide direction to state agencies. This 10 member permanent joint committee of the legislature develops budget and policy recommendations for funding appropriations to all state agencies, and completes fiscal analyses for proposed legislation. The joint-chairs are the Lieutenant Governor and the Speaker of the House.

The Health and Human Services Commission (HHSC) was created by the 72nd Texas Legislature (1991) to provide leadership and strategic direction for Texas' Health and Human Services (HHS) System. The responsibilities of HHSC have grown substantially since inception resulting in enhanced oversight of the HHS System. Governor Rick Perry named Mr. Thomas Suehs as the HHSC Executive Commissioner to replace retiring Executive Commissioner Albert Hawkins effective September 1, 2009 for a term to expire February 1, 2011. Previously, Mr.

Suehs served as the HHSC Deputy Executive Commissioner for Financial Services since 2003.

***/2013/ Mr. Thomas Suehs has announced his retirement as Executive Commissioner of HHSC effective August 31, 2012. Gov. Rick Perry has appointed Dr. Kyle Janek of Austin as executive commissioner of the Texas Health and Human Services Commission (HHSC) effective Sept. 1, 2012, and announced that Chris Traylor of Austin will serve as chief deputy commissioner. //2013//***

DSHS is the state agency responsible for the administration of Title V and is one of four HHS agencies under the umbrella of HHSC. The HHSC Executive Commissioner is authorized, with the governor's approval, to employ the DSHS Commissioner and to supervise and direct the activities of the position. Furthermore, HHSC has responsibility for coordinating the development and submission of joint agency strategic plans and a consolidated budget. HHSC is involved in policy development for all HHS agency programs and, as such, reviews all proposed rules and has final authority to adopt rules for each agency.

DSHS Commissioner David L. Lakey, MD, oversees hundreds of health-related prevention, direct care, regulatory, and preparedness programs employing approximately 12,500 employees. Prior to becoming Commissioner, Dr. Lakey served as an Associate Professor of Medicine, Chief of the Division of Clinical Infectious Disease, and Medical Director of the Center for Pulmonary and Infectious Disease Control at the University of Texas Health Center in Tyler. Dr. Lakey is board certified in pediatrics, internal medicine, infectious disease, and pediatric infectious disease.

DSHS performs its duties through staff located at the state headquarters in Austin and throughout eight geographical Health Service Regions (HSRs) statewide; through contracts with autonomous local health departments, community-based organizations, and other groups with a health-related mission; and in-concert with other state agencies and local partners.

Several resources within the DSHS organizational structure assist in program administration. The DSHS Council provides guidance to all programs regarding agency policies and rules. Functions related to administration, infrastructure, and coordination for all DSHS programs are organized under the following areas: Associate Commissioner, Chief Financial Officer, Chief Operating Officer, and Deputy Commissioner.

The Associate Commissioner is Ben Delgado. In this position, Mr. Delgado is directly involved in the day-to-day operations of the agency, addressing both program functions and business support functions. Mr. Delgado has 30 years of leadership experience, and extensive experience and skills in operational and administrative management. His work portfolio includes public health, child and adult protective services, regulatory, marketing, consumer protection, and workers' compensation.

***/2013/ Kirk Cole was named Associate Commissioner in September 2011. Mr. Cole previously served as the Director for the Center for Consumer and External Affairs and has more than 20 years experience in state government. He has a Master of Urban Planning from Texas A&M University. //2013//***

The Chief Financial Officer is Machel Pharr who has served in this position since 2002. Ms. Pharr is responsible for administering and directing all DSHS financial activities including accounting, budgeting, grants management, client services contracting, and policy and procedure development.

*/2012/ Bill Wheeler joined DSHS as Chief Financial Officer in 2010 with over 16 years of state experience, most recently as CFO with the Department of Assistive and Rehabilitative Services. //2012//*

The Chief Operating Officer is Dee Porter. Ms. Porter oversees administrative, operations, and

support services including information technology, contract oversight, health information and vital statistics, general counsel, and operations management.

/2012/ Ed House joined DSHS as Chief Operating Officer in June 2011 with over 20 years of experience at DSHS, and the Texas Commission on Environmental Quality (TCEQ) and the Texas Water Commission. //2012//

The Deputy Commissioner is Luanne Southern, MSW, who manages areas that provide coordination and consultation functions across DSHS programs. These functions include internal and external communications, legislative relations, integration and process improvement, project management, and workforce development.

/2012/ DSHS implemented the Performance Management Initiative as a priority project in May 2011 to focus on leadership development and organizational learning, internal process management, performance measurement, Continuous Quality Improvement (CQI) activities and utilization of CQI tools . A Performance Management Team will provide DSHS and the public health system in Texas with tools and resources to implement the Performance Management Initiative. The Performance Management Team is organizationally located in the Office of State Epidemiologist (OSE), under the leadership of Dr. Thomas Erlinger. //2012//

***/2013/ Dr. Thomas Erlinger announced his departure from DSHS effective August 31, 2012. //2013//***

DSHS programs are organized under five divisions: Mental Health and Substance Abuse Services, Regulatory Services, Prevention and Preparedness Services, Regional and Local Health Services, and Family and Community Health Services (FCHS).

Title V administrative functions and a majority of the programs supported by Title V are organized within FCHS. Since July 2004, Evelyn Delgado has been the Assistant Commissioner of FCHS. Ms. Delgado has over 30 years of management experience in the private and public sectors. She previously served as Assistant Deputy Commissioner of Long Term Care Regulatory at the Texas Department of Human Services, protecting the health and safety of elderly and disabled citizens residing in nursing homes and other long term care facilities throughout Texas. Ms. Delgado has a business administration degree from Trinity University and is a graduate of the LBJ School of Government Governor's Executive Training program.

FCHS is comprised of 3 sections and 2 offices under Ms. Delgado's leadership: the Community Health Services (CHS) Section, the Specialized Health Services Section (SHS), the Nutrition Services Section, the Office of Title V and Family Health (OTV&FH), and the Office of Program Decision Support (OPDS). FCHS has administrative responsibility for most of the DSHS programs dedicated to women and children's health, including Title V and CYSHCN, Medicaid - EPSDT, WIC, family planning, and breast and cervical cancer screening/diagnosis.

Sam B. Cooper III, MSW, LMSW, was named the State Title V Director effective April 2009. Mr. Cooper also serves as OTV&FH Director overseeing the management and administration of Title V, the Texas Primary Care Office, and the Community Health Worker/Promotora Program. Prior to this position, Mr. Cooper served as the Title V Block Grant Administrator among his many roles in more than 20 years of health and human services experience, primarily in the areas of MCH and CYSHCN. Mr. Cooper received his BA in Psychology and MSW from University of Houston. He is a Licensed Master Social Worker.

***/2013/ As part of an agency reorganization, the Texas Primary Care Office was moved under the Preventive and Primary Care Unit (PPCU) in the Community Health Services Section and five maternal and child health subject matter experts from the Office of Program Decision Support were moved to the Office of Title V and Family Health effective September 1, 2011. Additionally, one maternal and child health nurse consultant was***

***moved from PPCU to OTV&FH. //2013//***

The Title V Director and the Block Grant Administrator manage the general administration and reporting functions for the MCH Services Block Grant; consult with Title V-funded programs to ensure that rules, policies, and procedures comply with federal regulations and are delivered in a manner congruent with the intent of Title V; and identify and facilitate opportunities for coordination and integration of resources related to women and children within DSHS and across the HHS System. Collaborative work includes partnering with HHSC on Medicaid and CHIP, as well as with the Office of Program Coordination for Children and Youth to support efforts in coordinating programs and initiatives that serve children and youth.

OPDS works to inform, develop, and implement evidence-based practices leading to an improved understanding and response to the health-related needs of women and children in Texas. Five subject matter experts in the areas of women's and perinatal health, child health, adolescent health, child fatality review, and clinical issues for these populations are funded through Title V to provide consultation to internal and external partners and to plan and implement initiatives that address MCH issues. In addition to subject matter expertise, OPDS provides MCH epidemiology support for program areas including expert statistical analysis, data management and performance measure reporting, geographical/spatial analysis, research design, consultation and evaluation, and literature reviews. OPDS is responsible for the State Systems Development Initiative (SSDI) and the Texas Pregnancy Risk Assessment and Monitoring System (PRAMS).

CHS consists of two Units: the Preventive and Primary Care Unit (PPCU) and the Performance Management Unit (PMU). PPCU is responsible for developing and implementing operational policy and procedures and for providing technical assistance to contractors for the following Title V-funded programs: family planning, prenatal, child health and dental, and dysplasia. In addition, CHS administers breast and cervical cancer screening/diagnosis, primary health care, county indigent health care, and epilepsy services. Clinical oversight for Title V-funded programs is provided by an on-staff board-certified obstetrician/ gynecologist medical consultant and a team of nurses to ensure that clinical protocols and policies utilized by contractors are consistent with nationally-recognized standards, current scientific literature, and Texas statute.

***/2013/ As part of an agency reorganization, PPCU now oversees the Texas Primary Care Office effective September 1, 2011. //2013//***

PMU is responsible for developing and managing contracts for all CHS programs, including those that are Title V-funded. These activities include coordinating the contract procurement process, tracking contractor expenditures and performance measures, and ensuring compliance with contract terms and conditions through monitoring performance reports and conducting on-site quality assurance reviews.

Specialized Health Services Section consists of three Units: the Purchased Health Services Unit (PHSU), the Health Screening and Case Management Unit (HSCMU), and the Newborn Screening Unit (NBSU).

The position of Title V CSHCN Director held by Lesa Walker, MD, MPH, is located in PHSU where she also serves as Manager of the Systems Development Group and Medical Director of the CSHCN Services Program (CSHCN SP). Dr. Walker has served in a state and federal leadership role in CSHCN SP for over 24 years.

***/2012/ Dr. Lesa Walker retired from DSHS in August 2010 after serving as the Texas Title V CSHCN Director for 25 years. Dr. James McKinney, served as Title V CSHCN Director from March to August 2011. Carol Labaj, RN, BSN, assumed the role of interim Title V CSHCN Director in August 2011. //2012//***

PHSU develops and administers health care benefits and services through the CSHCN SP, as

well as provides medical expertise and consultation to providers of CYSHCN. PHSU also administers a client services program for persons with end stage renal disease and the State organ donation registry and awareness program and oversees eligibility determination, enrollment services, third-party billing, and provider reimbursement for programs within PHSU. CSHCN SP enrolls and reimburses individual health care benefit providers on a fee-for-service basis. In addition to health care benefits, CSHCN SP provides case management services to CYSHCN and their families, including those on the waiting list for health care benefits and also those not eligible for CSHCN SP health care benefits, using both regional DSHS staff and contracted providers. CSHCN SP also provides family supports through both the fee-for-service health care benefits and through contractors.

HSCMU administers federally-mandated preventive health services (EPSDT) to Medicaid eligible clients from birth through 20 years of age through the Texas Health Steps program. Client services include medical and dental care and case management. HSCMU also develops and administers mandated screening programs, including spinal, vision, lead, and hearing as well as case management services all supported by Title V.

NBSU oversees testing, follow-up, and case management resulting from screening all newborns in Texas for 28 inheritable and other disorders. Additionally, NBS provides assistance to uninsured children identified with an abnormal screen to ensure access to confirmatory testing or treatment. NBS administers Title V-funded genetics services including laboratory testing and diagnosis to help prevent and/or inform low-income families about genetic disorders, follow-up and support services if needed, and genetic counseling.

In addition to central office staff, there are Title V-funded regionally-based staff in each of the eight HSR headquarter offices. DSHS maintains regional offices to provide core public health services in areas of the state with no local health department. Title V-funded positions provide case management, perform population-based activities, and provide front-line technical assistance, training, and quality assurance services to Title V-funded contractors. Consistent with Title V priorities and performance measure activity plans, Title V-funded staff in each HSR develops and implements key initiatives in the area of population-based services. In recent years four areas of focus included access to care, injury prevention, obesity reduction, and teen pregnancy prevention.

***An attachment is included in this section. IIIC - Organizational Structure***

## **D. Other MCH Capacity**

### NUMBER AND LOCATION OF STAFF WORKING IN TITLE V PROGRAMS

Attachment III. D. Other MCH Capacity - Title V Staff details the number and location of staff that are funded by Title V. Compared to FY09, there was a net increase of slightly more than 2 FTEs in FY10 to ensure continued funding of critical positions related to maternal and child health.

***//2013/ Attachment III. D. Other MCH Capacity has been updated as of June 2012. Compared to FY11, there was a net decrease of more than 25 FTEs through required agency reductions; however, DSHS worked to ensure critical positions related to maternal and child health remain filled to maintain state services. //2013//***

CSHCN SP employs staff who are parents or siblings of CYSHCN that participate in the program decision-making process and may offer their insights and feedback to the program on an ongoing basis. A CSHCN SP former staff person is the Texas Family Delegate to the Association of Maternal and Child Health Programs (AMCHP) and was accepted as an AMCHP Family Mentor and Family and Youth Leadership Committee member.

### SENIOR LEVEL MANAGEMENT BIOGRAPHIES

Supplemental to the information provided on senior-level management in the previous section, the following biographies detail the qualifications and experience of additional key DSHS management responsible for the provision of maternal and child health-related services in Texas.

Michael Maples, MAHS, LPC, the Assistant Commissioner of the Division of Mental Health and Substance Abuse (MHSA) since August 2008, is responsible for state hospital operations and community mental health and substance abuse contracts. Previously, Mr. Maples served as the Director of MHSA Programs at DSHS, providing leadership, expertise, and oversight for child and adult mental health and substance abuse program policy throughout the State. He has over 15 years of experience in public MHSA service delivery, operations, and development of public behavioral health policy. Mr. Maples received his BA in Psychology from Texas A&M University and his MAHS in Psychology from St. Edwards University. He is a Licensed Professional Counselor and a Licensed Marriage and Family Therapist.

Emilie Becker, MD, has served as Medical Director for Behavioral Health in the DSHS MHSA Services Division since June 2009. She provides support and guidance to the medical directors at the state hospital facilities and serves as a consultant, advising on behavioral health-care issues, to community mental health centers and local providers of substance abuse services. Previously, Dr. Becker was attending physician at Austin State Hospital and acting medical director at the Austin Travis County Mental Health and Mental Retardation and was the child psychiatrist for its Child and Adolescent Emergency Team. Dr. Becker has worked at the Bellevue Hospital in New York, in juvenile corrections settings, and had a private practice. Dr. Becker has training in child and adolescent psychiatry, as well as forensic psychiatry.

Adolfo M. Valadez, MD, MPH serves as the Assistant Commissioner for Prevention and Preparedness Services. Dr. Valadez is responsible for overseeing infectious and chronic disease control and prevention programs, disaster preparedness and response activities, and laboratory services. Prior to coming to DSHS, Dr. Valadez served as the medical director and health authority for the Austin/Travis County Health and Human Services Department. In the past, Dr. Valadez also served as the medical director of the Martha Eliot Health Center in Jamaica Plain, Massachusetts and as a primary care provider. Dr. Valadez received his medical degree from the University of Texas Medical Branch at Galveston.

***/2013/ Lucina Suarez, PhD, has served as the Interim Assistant Commissioner for Prevention and Preparedness Services since June 6, 2012. Dr. Suarez has a Doctoral degree in epidemiology from the University of Texas School of Public Health and a Master of Science degree in Biostatistics from the University of Pittsburgh School of Public Health. She is also a Full Professor, Adjunct Faculty, Biostatistics and Epidemiology Department at Texas A&M Rural School of Public Health and serves on the External Advisory Committee to the Institute for Health Promotion Research, University of Texas Health Science Center at San Antonio. //2013//***

Jamie Clark, MSPH, has served as OPDS Director since March 2010. Her DSHS experience includes serving as a research specialist and as the Health Assessment and Reporting Manager in OPDS. Previously, Ms. Clark was the regional epidemiologist for the Utah Department of Health and was a senior research analyst for the Idaho Department of Health and Welfare. Ms. Clark has a Bachelor of Science in Behavioral Science and Health and a Master of Science degree in Public Health from the University of Utah.

***/2012/ Rebecca Martin, PhD, MSW has served as OPDS Director since May, 2011. Dr. Martin has a doctoral degree in epidemiology/biostatistics/health law and a master's degree in medical social work. Her past experience includes serving as the director of epidemiology at RTI Health Solutions, director of North Carolina Central Cancer Registry, and as an epidemiologist at the Cancer Prevention and Detection Program at MD Anderson Cancer Center in Houston. //2012//***

***/2013/ Dr. Martin has resigned from DSHS effective September 14, 2012. //2013//***

L. Jann Melton-Kissel, RN, MBA, is Director for the Specialized Health Services (SHS) Section, since September 2004. SHS is comprised of three units: Newborn Screening (NBSU), Purchased Health Services Unit (PHSU), and Health Screening and Case Management Unit (HSCMU). Ms. Melton-Kissel is responsible for directing, planning, implementing, and evaluating health services for children. The SHS Section continues its focus on increasing service integration, and assuring that systems are accessible for clients, community members, and providers. Ms. Melton-Kissel began employment with the agency in 1986 and has held multiple positions at various levels of responsibility, gaining experience in budget and management.

Linda M. Altenhoff, DDS, is the State Dental Director and Manager of the Oral Health Branch in HSCMU since November 2004. Dr. Altenhoff oversees the oral health aspects of the Texas Health Steps (EPSDT) Program, the Public Health Dental Program, and the Sealant and Oral Health Promotion Programs. She has previously served as Director of Texas Health Steps, Medicaid Medical Transportation, Oral Health, and was a Regional Dental Director at DSHS. Dr. Altenhoff has experience in private practice and as a consultant. She is active in state and national associations including being a board member of the Medicaid and SCHIP Dental Association and was Director of the Association of State and Territorial Dental Directors. Dr. Altenhoff received her Doctor of Dental Surgery degree from the University of Texas Health Science Center at San Antonio.

Debra Freedenberg, MD, PhD, is the Genetics Physician Consultant for the Newborn Screening Genetics Branch since January 2009. She has worked in Genetics for over 33 years, most recently as an Associate Professor at Vanderbilt University Medical Center in Nashville, Tennessee. Dr. Freedenberg holds degrees in Biology, Biomedical Sciences, and Medicine; is a member of the American Medical Association, Society of Inherited Metabolic Disease, American Society of Human Genetics, and Fellow of the American Academy of Pediatrics; and is a Founding Fellow of the American College of Medical Genetics. She is a Diplomat of the American Board of Pediatrics and the American Board of Medical Genetics. Dr. Freedenberg authored and co-authored more than 22 published articles in various academic journals.

Carol Pavlica Labaj, RN, BSN, Manager of PHSU since March 2007, is responsible for 4 programs: CSHCN SP, Kidney Health Care, Hemophilia Assistance Program, and the Glenda Dawson Donate Life Texas-Registry. Responsibilities include interpreting and implementing federal, state, and department policies; developing and implementing program strategic planning; coordinating client eligibility and service benefits administration; developing and maintaining mechanisms to ensure that administrative and client service expenditures remain within budgetary limitations; and meeting state and federal performance measures. Mrs. Labaj has worked in the public health field since 1972.

Lesa Walker, MD, MPH, is the Title V Children with Special Health Care Needs (CSHCN) Director and Medical Director of the CSHCN Services Program (CSHCN SP) and Manager of the Systems Development Group, PHSU. She oversees the planning and implementation of Title V CSHCN activities, initiatives, community-based contractor services, and systems development. She manages the Glenda Dawson Donate Life-Texas Registry. Dr. Walker has served in a state and federal leadership role in CSHCN SP for over 24 years. She authored many program policies, reports, articles, and rules; and contributed to Healthy People 2010 relating to people with disabilities. She is board certified in General Preventive Medicine/Public Health.

*/2012/ Dr. Lesa Walker retired from DSHS in August 2010 after serving as the Texas Title V CSHCN Director for 25 years. Dr. James McKinney, Title V CSHCN Director since March 2011 is a Doctor of Osteopathic Medicine and Board-Certified Radiologist with experience serving on a county Board of Health. //2012//*

***/2013/ Carol Labaj, RN, BSN, assumed the role of Interim Title V CSHCN Director in August***

**2011. //2013//**

Dale A. Ellison, MD, is the Policy and Program Development Branch Manager and assistant medical director for PHSU effective May 2008. Dr. Ellison is board certified in anatomic and clinical pathology with sub-specialty boards in pediatric pathology. She has worked in the field of pediatric pathology for more than 15 years, a career that includes positions as director of: microbiology, surgical pathology, and hematology coagulation lab. She was the acting medical director of the laboratory at Dell Children's Medical Center prior to coming to DSHS.

***//2013/ Dr. Ellison was named Medical Director for PHSU effective March 1, 2012. //2013//***

Patrick Gillies, MPA, has served as the Director of the Community Health Services (CHS) since February 2008. CHS is comprised of two units: Preventive and Primary Care and Performance Management. These units are involved in the implementation and quality assurance of a number of direct services funded by Title V. Mr. Gillies has worked for the State of Texas for 12 years providing program and contractual management and developing health purchasing systems. Mr. Gillies received his Master of Public Administration degree from Texas Tech University.

***//2013/ Imelda M. Garcia, MPH, has served as the Director of the Community Health Services (CHS) since December 2011. Ms. Garcia has worked for the State of Texas for almost 6 years within the CHS Section as a Legislative Liaison, Branch Manager of Preventive Care for the Preventive and Primary Care Unit (PPCU) as well as Unit Manager for PPCU. Ms. Garcia received her Master of Public Health degree from Columbia University. //2013//***

Janet D. Lawson, MD, FACOG, is the CHS Medical Consultant since November 2009. She provides medical consultation for the programs within CHS including breast and cervical cancer, prenatal, child health, primary health care, and family planning services. Since 1996, she has served in a variety of positions at DSHS, including Director of the Division of Women's Health; Medical Consultant for the Bureau of Clinical and Nutrition Services; leadership in the Bureau of Community Oriented Public Health and the Bureau of HIV/STD Prevention; Medical Director for the South Texas Health Care System; and was Assistant Commissioner for the Division of Regional and Local Health Services. Dr. Lawson is board certified by the American Board of Obstetrics and Gynecology.

Mike Montgomery is the Director of the Nutrition Services Section in FCHS since 2001. He provides overall direction, policy development, and policy enforcement for WIC and the Farmers' Market Nutrition Program. Previously, he led the Texas WIC project development team for the Electronic Benefits Transfer (EBT) project and was Chief of the Bureau of Nutrition Services before leading the Children's Health Bureau. Mr. Montgomery has more than 30 years experience with WIC, having served across the spectrum of management and administration in positions at the federal, state, and local level including 22 years with the USDA's Food and Nutrition Service. Mr. Montgomery has a Bachelor of Science degree from the State University of New York with majors in Sociology and Psychology.

#### TENURE OF STATE MCH WORKFORCE

DSHS employees have an average age of 44 years; approximately 63% of the DSHS workforce is 41 years or older. Approximately 45% of DSHS employees have 10 or more years of service. About 11% of the DSHS workforce is currently eligible to retire from state employment. Over the next 5 years, over one-fourth of the agency workforce will reach retirement eligibility. The turnover rate in FY09 at DSHS was higher than the state average. DSHS anticipates there will be a need for additional health-related services as the population of the state increases and expects increased competition for qualified job applicants.

Based on these trends and current employment conditions, DSHS anticipates continued difficulty

recruiting and retaining qualified and experienced employees. Workforce challenges include: retirement of numerous management and professional staff in the next 5 to 10 years; increased workloads; severe nursing staff shortages; limited funding for training and travel; increased need for bilingual staff; limited or lack of career ladders; and non-competitive starting salaries. DSHS has difficulty filling vacant positions for registered nurses, human services specialists (public health case managers), epidemiologists, physicians, dentists, laboratory technicians, and medical technologists.

#### PROJECTED CHANGES TO WORKFORCE IN THE COMING YEAR

Dr. Lesa Walker, the Title V CSHCN Director for the past 24 years, has announced her retirement from DSHS effective August 31, 2010. Dr. Walker's retirement represents a significant change in the Texas MCH workforce as her passion and commitment for the families of Texas that she has touched through her work at DSHS are immeasurable.

State budget reductions that may impact Title V programs are possible. In January 2010, due to the uncertainty of Texas' economic future and the national recession, Governor Rick Perry, Lieutenant Governor David Dewhurst, and Speaker of the House Joe Straus requested each agency to submit a plan to identify savings of 5% of state general revenue and general revenue dedicated appropriations for the FY10-11 biennium. This request was followed by a Health and Human Services (HHS) Executive Memorandum from HHSC Executive Commissioner Thomas Suehs that implemented a freeze on hiring, merit awards, and overtime for all HHS agencies.

At the end of May 2010, DSHS received instructions for the FY12-13 Legislative Appropriations Request (LAR), the process by which DSHS requests funding from the legislature for the next two years. In these instructions, each state agency was asked to submit a plan for reducing general revenue budgets by an additional 10%. This amount is in addition to the general revenue reductions for the FY10-11 biennium. The outcome will not be final until May 2011 when the 82nd Texas Legislative Session concludes.

//2012/ The 2012-2013 General Appropriations Act was passed by the 82nd Legislative, First Called Session. It included a decrease in General Revenue (GR) funding for family planning and mental health services and several health care loan repayment programs, and reductions in provider reimbursement rates for Medicaid and Title V fee for services contracts. DSHS leadership is currently determining impact on agency programs, including Title V-funded programs. //2012//

***//2013/ Mr. Thomas Suehs, Executive Commissioner of the Texas Health and Human Services Commission, has announced his retirement from state service effective August 31, 2012. Gov. Rick Perry has appointed Dr. Kyle Janek of Austin as executive commissioner of the Texas Health and Human Services Commission (HHSC) effective Sept. 1, 2012, and announced that Chris Traylor of Austin will serve as chief deputy commissioner. //2013//***

***An attachment is included in this section. IIID - Other MCH Capacity***

#### **E. State Agency Coordination**

Given the large size of Texas, geographically and demographically, there are numerous efforts addressing MCH needs throughout various state and local government and private/non-profit organizations. Since state legislation and/or funding grantees charge multiple agencies at both the state and local levels with responsibility for various MCH activities, DSHS recognizes the importance of partnership building and collaboration as critical components in addressing MCH needs if these efforts are to be successful. In addition to staff that work to administer the Title V Block Grant, subject matter experts funded by Title V in the areas of women's and perinatal health, child health, adolescent health, child fatality, CYSHCN, and clinical MCH issues are

charged with working collaboratively across programs and agencies throughout the state.

## ORGANIZATIONAL RELATIONSHIPS AMONG HHS SYSTEM

Title V collaborates most closely with HHSC and agencies under the auspices of HHSC, including the Department of Family and Protective Services (DFPS), Department of Aging and Disability Services (DADS), and Department of Assistive and Rehabilitative Services (DARS), collectively known as the Health and Human Services (HHS) System.

HHSC oversees the operations and policies of the entire HHS System, and directly operates the Medicaid program, the Children's Health Insurance Program (CHIP), and several family support programs. HHSC also operates a consolidated eligibility determination function for several major programs and provides consolidated, coordinated administrative support for all HHS System agencies.

For example, in Texas, a woman is eligible for Medicaid if she meets the requirements for TANF, or she is pregnant and is at or below 185% FPL. Although CHIP serves children age 0-19 years from low-income families, coverage was expanded in 2007 to provide prenatal care to pregnant women with a family income up to 200% FPL who are ineligible for Medicaid. By virtue of serving similar populations with comparable services, Medicaid, CHIP, and Title V must partner closely to meet the needs of women and children in the state without duplication of efforts. Through an integrated screening process, individuals are referred to the appropriate program based on eligibility criteria. Moreover, all Title V contracted fee-for-service providers are required to assist individuals in the eligibility screening process and to be Medicaid providers to help ensure the client a seamless transition from eligibility screening to receiving services.

Continuing with the example of prenatal services, HHSC and DSHS have worked to minimize delays in access to care, ultimately agreeing that Title V-funded prenatal services contractors provide two prenatal visits during the time an application for CHIP Perinatal benefits is in process. Furthermore, DSHS encourages all contracted providers to become CHIP Perinatal providers to once again ensure the client a seamless transition to services. Finally, Title V does not participate in rate setting activities, but instead uses Medicaid rates as a guide to reimbursing fee-for-service contractors.

Specific to CYSHCN, Title V staff participate on the Benefits Management Workgroup, a policy development and coordination effort led by HHSC to ensure collaboration between Medicaid and CSHCN SP policy implementation. CSHCN SP provides "wrap around" services (e.g. travel reimbursement, case management, family support services) to CHIP and Medicaid clients when needed.

//2012/ In 2010, Texas implemented a Medicaid Buy-In Program for families who need health insurance for their children with special needs but who make too much to qualify for Medicaid and cannot afford private insurance.

In 2011, the State Kids Insurance Program (SKIP) was abolished by the 82nd Legislature, First Called Session now that states may enroll children of state employees who qualify for CHIP.

In 2009, the Texas Legislature directed HHSC to implement a comprehensive benefit package for adults with Medicaid who have a substance abuse disorder, and to clarify the existing benefits for children needing similar treatment. Access to outpatient treatment services such as counseling and medication assisted therapy for adults began in September 2010. Residential treatment such as detoxification became available in January 2011. //2012//

With the potential for overlap of Medicaid, CHIP, and DSHS programs, an executive team has been established through the DSHS Office of Priority Initiatives Coordination (OPIC). The purpose of OPIC is to provide support to the DSHS Commissioner's Office to ensure that the vast

array of legislative mandates, exceptional item funding, and agency priority projects are identified, resourced, and managed in a manner that meets DSHS' obligations to partners, clients, stakeholders, and oversight agencies. Most recently, agency leadership established the DSHS Medicaid Executive Management Team to ensure proactive cross-agency communication, collaboration, and risk/issue management related to the following three areas: Medicaid Policy, Texas Health Steps (EPSDT), and other Medicaid-related efforts.

Because multiple agencies have programs and activities related to or responsibilities for parts of Medicaid and CHIP, DSHS, DARS, DFPS, and DADS have established a system of communication that supports collaborative efforts in planning and the administration of these and other health and social service programs. An electronic project alert system has been created to ensure that as programmatic changes occur, all agencies are provided basic information that can be used to determine whether more involvement through communication on project status is sufficient, or whether formal participation on work groups is needed. Efforts are led by staff in HHSC, but each of the four HHS agencies has ongoing communication mechanisms in place to promote effective coordination.

Opportunities which support collaborative efforts for interagency collaboration include:

The Texas CHIP Coalition -- The Texas CHIP Coalition was formed in 1988 to bring together state and local organizations to support adequate state funding and program improvements for CHIP and Children's Medicaid. The coalition engages in public education and advocacy, working closely with state agencies and the Texas legislature on behalf of children and their families.

The Task Force for Children with Special Needs -- The creation of the Task Force for Children with Special Needs by the 81st Texas Legislature (2009) provides a focused opportunity for collaboration regarding services for CYSHCN and their families. The Task Force was established with subcommittees to address key issues in the areas of health, mental health, education, transitioning youth, juvenile justice, long-term care, and early childhood intervention and crisis prevention. The DSHS Assistant Commissioner for FCHS serves as the chair of the Health Subcommittee and CSHCN SP staff members are actively involved in providing information and expertise. Due to the high-level visibility, leadership, charge, and accountability of the Task Force, there will be a tremendous opportunity to coordinate, improve, and advance services for CYSHCN in Texas.

***//2013/ Following release of its Five-Year Strategic Plan, the Task Force formed an Executive Steering Committee (ESC), which included the DSHS Assistant Commissioner for FCHS as an appointee. At the recommendation of the ESC, the Task Force prioritized implementation of two goals, (1) organized and reliable information and (2) prevention and early identification, during the 2012-2013 biennium. The vision for organized and reliable information included creating a comprehensive website targeting multiple stakeholders, including families, CYSHCN, providers, agency personnel, and others who assist with access to services and/or care coordination. Key to the implementation of the website was contracting with a professional social marketing partner to conduct a formative assessment. DSHS, through Title V funding, joined the Department of Aging and Disability Services (DADS) and the Health and Human Services Commission (HHSC) in an inter-agency agreement, each contributing an equal share toward funding the formative assessment contract. The formative assessment will: analyze existing websites targeting CYSHCN and identify best practices; engage both English and Spanish-speaking family members throughout Texas in 10 focus groups; interview professionals and 2-1-1 operators; determine the optimal design and content; and recommend strategies for constructing and maintaining the Web site. Following initiation of the formative assessment, the Task Force began developing plans toward implementation of the prevention and early identification goal. //2013//***

The Council on Children and Families -- The DSHS Deputy Commissioner of Health represents

DSHS on the Council on Children and Families. The Council was established by the 81st Texas Legislature (2009) to help improve the coordination of state services for children by coordinating the state's health, education, and human services systems to ensure that children and families have access to needed services; improving coordination and efficiency in state agencies, advisory councils on issues affecting children, and local levels of service; prioritizing and mobilizing resources for children; and facilitating an integrated approach to providing services for children and youth. The membership on the Council is composed of executive leadership from HHS agencies, juvenile justice agencies, Texas Education Agency (TEA), Texas Workforce Commission, and representatives from the public including two public representatives who are parents of children who have received services from an agency represented on the Council, and two representatives who are young adults or adolescents who have received services from an agency represented on the Council.

/2012/ The Council gathered input from public members, communities, and model programs to develop the Council on Children and Families 2010 Report: Promoting Healthy Children ~ Strengthening Families. It is included as an attachment and includes legislative recommendations and plans for future work objectives. //2012//

The Interagency Coordinating Council (ICC) for Building Healthy Families -- This Council was established by the 79th Texas Legislature (2005) and is charged with facilitating communication and collaboration concerning policies for the prevention of and early intervention in child abuse and neglect among state agencies whose programs and services promote and foster healthy families. State agencies represented on the Council include HHSC, DSHS, DFPS, DADS, DARS, Texas Youth Commission, TEA, Texas Workforce Commission, Office of the Attorney General, Texas Juvenile Probation Commission, and Texas Department of Housing and Community Affairs. DSHS is represented on the Council by the State Title V Director. In 2007, the 80th Texas Legislature (2007) provided new direction; it re-authorized the Council, added DARS as a member, and directed the Council to continue its collaborative work. New requirements included an evaluation of state-funded child maltreatment prevention programs and services and the development of a DFPS Strategic Plan for Child Abuse and Neglect Prevention Services undertaken in consultation with the Council.

Office of Program Coordination for Children and Youth (OPCCY) -- DSHS Title V staff work closely with HHSC's OPCCY. OPCCY assists in coordinating programs and initiatives that serve children and youth across the HHS System. In addition, it also oversees the operation of various children's programs and initiatives from the following areas: Community Resource Coordinating Groups (CRCGs), Texas Integrated Funding Initiative (TIFI), Children's Policy Council, Raising Texas, and Healthy Child Care Texas (HCCT).

/2012/ A report was prepared for OPCCY in January 2011 related to Early Childhood Behavioral Health Consultation (ECBHC) to identify challenges, resources, and opportunities for consideration when developing a plan to promote and support ECBHC in Texas. //2012//

CRCGs are local interagency groups comprised of public and private agency representatives who develop service plans for individuals and families whose needs often highlight gaps in the regular service delivery system and require more intensive service coordination. The 70th Texas Legislature (1987) created CRCGs and directed state agencies serving children to develop a community-based approach to better coordinate services for children and youth who have multi-agency needs and require interagency coordination. CRCGs are organized and established on a county-by-county basis with members from public and private sector agencies and organizations and include parents, consumers, or caregivers as members. Regional Title V-funded social workers serve on all local CRCGs and central office DSHS staff are represented on the state advisory committee.

DSHS staff serve as representatives to TIFI which supports flexible funding collaboration between governmental and private sector agencies to serve children and youth with complex mental health

needs. TIFI assists in developing systems of care that focus on individualized services that move beyond traditional child-centered mental health services to encompass more comprehensive supports for the entire family.

***/2013/ TIFI did not receive ongoing state funding; however, Texas received federal Substance Abuse and Mental Health Services Administration (SAMHSA) funding through a Community Demonstration for System of Care Expansion Grant, known in Texas as the Achieving Successful Systems Enriching Texas (ASSET) Grant. DSHS staff and staff from other agencies previously collaborating in an advisory capacity for the TIFI were re-directed toward the ASSET Grant project. The purpose of the ASSET Grant is comparable to that of the TIFI and is to develop a strategic plan that will expand System of Care practices for children with serious emotional disturbances in Texas. //2013//***

CSHCN SP staff represents DSHS on the Children's Policy Council. The Children's Policy Council assists HHS agencies in developing, implementing, and administering family support policies and related long-term care and health programs for children. Membership is composed primarily of family members of consumers and is supported by state agencies such as HHSC, DSHS, and DFPS. The Council provides recommendations to the state legislature on issues such as: access of a child or a child's family to effective case management services; transition needs of children who reach an age at which they are no longer eligible for services; collaboration and coordination of children's services and the funding of those services between state agencies; and effective permanency planning for children who reside in institutions or who are at risk of placement in an institution.

Raising Texas is a statewide, collaborative effort to strengthen Texas' system of services for young children and families so that all children enter school healthy and ready to learn. Through the collaborative partnership of 9 state agencies, 16 community based agencies and 60 key stakeholders, a state plan has been developed to improve the current system of services for all children age birth to 6. The Raising Texas strategic plan promotes evidence-based practice and increases coordination among health, behavioral health, and education services. DSHS MCH and CSHCN SP staff serve on the Raising Texas Initiative supporting the Medical Home and Parent Education and Family Support sub-committees.

HCCT brings together health care professionals, early care and education professionals, child care providers, and families to improve the health and safety of children in child care. The current HCCT initiative has two approaches to training consultants. It trains qualified individuals to be Child Care Health Consultants (e.g., RNs, child development specialists, early childhood education specialists) or Medical Consultants (e.g., physicians, residents, physician assistants, nurse practitioner). The goals for HCCT are to maximize the health, safety, well-being, and developmental potential of all children so that each child experiences quality child care within a nurturing environment, and to help increase children's access to preventive health services, including a medical home.

Medical Home Work Group -- Coordinated by CSHCN SP staff, the Medical Home Workgroup strives to enhance the development of and access to medical homes in Texas. Workgroup membership includes family members of CYSHCN, representatives from community organizations, state agencies and family advocacy organizations, community physicians and other health care providers, insurers, and other partners. The workgroup has developed a strategic plan to achieve the goal that all children in Texas, including CYSHCN, will receive their health care in a medical home. A key part of the strategic plan is to increase the number of health care practitioners who provide a medical home.

/2012/ HHSC, in coordination with DSHS, implemented the Medicaid Child Obesity Prevention Pilot on November 1, 2010, to decrease the rate of obesity, improve nutritional choices, increase physical activity levels, and achieve long-term reductions in Medicaid costs incurred as a result of obesity.

The HHS Enterprise agencies continue interagency partnerships with the HHSC Office of Border Affairs, the Texas Workforce Commission (TWC), local workforce development boards, the Texas Education Agency (TEA), local school districts, educational service centers and community-based organizations, and promotora organizations to implement the Texas-Mexico Border Colonias Initiative, a coordinated outreach effort to enhance conditions supporting good health and self-sufficiency in these areas. //2012//

#### RELATIONSHIP WITH STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS, FQHCS, AND PRIMARY CARE ASSOCIATIONS

Title V funds the provision of direct and enabling health care services for women seeking family planning, dysplasia, and prenatal care; for infants, children, and adolescents needing well-child check-ups and dental care; children and youth with special health care needs and their families seeking coordinated health care services tailored to their individual needs; for families interested in genetic screening and counseling services, and for school-based health centers. The majority of these services are provided through contracts with local providers including city/county health departments, hospital districts, school districts, Federally Qualified Health Centers (FQHCs), non-profit agencies, and individual providers.

In addition to direct and enabling services, Title V funds population-based and infrastructure building services carried out by local entities. For example, DSHS implemented the Texas Healthy Adolescent Initiative (THAI) to improve the overall health and well-being of Texas adolescents, age 10-18 years. THAI provides funding for Local Community Leadership Groups to conduct a needs assessment and develop a strategic plan for their community to address adolescent health through a comprehensive youth development approach. Six communities in Texas were selected to participate in this initiative beginning September 2009 in Longview, San Antonio, Fort Worth/Dallas, Austin, Houston, and Lubbock. Additionally, Title V staff coordinates school health programming with TEA and other DSHS programs with the goal that students receive a program of physical and health education, appropriate health services, and a nurturing environment. Regional School Health Specialists are supported through Title V funding and are stationed in each of the 20 TEA Regional Education Service Centers.

Title V-funded staff have collaborative relationships with non-profit and professional organizations with an interest in maternal and child health, including among others: the Texas Medical Association, Texas Academy of Family Physicians, Texas Nurses Association, Texas Association of Obstetricians and Gynecologists, Texas Dental Association, Texas Association of Local Health Officials, Texas Association of Community Health Centers, Texas Association of Local WIC Directors, Texas Mental Health America, Children's Policy Council, Promoting Independence Advisory Committee, Texas Parent to Parent, March of Dimes, Texas Council on Developmental Disabilities, Early Childhood Intervention Advisory Council, Texas Pediatric Society, Traumatic Brain Injury Advisory Council, and the Leadership and Education in Adolescent Health (LEAH) Advisory Committee. Through these relationships, information, knowledge, and resources are shared and the entities work together to further joint projects and common goals. Many of these groups issue formal reports and submit recommendations to the Texas Legislature.

#### RELATIONSHIP TO PROFESSIONAL EDUCATION PROGRAMS AND UNIVERSITIES

DSHS in collaboration with HRSA Region VI Title V Directors (Texas, Louisiana, New Mexico, Oklahoma, and Arkansas) anticipates enhanced training opportunities and technical assistance from the University of Texas and Baylor Medical Center Multimodal MCH Training Program that will help build maternal and child health staff expertise and MCH public health infrastructure. Both organizations have strong ties to Title V leaders and know the diverse needs of the MCH populations in each state.

DSHS MCH and CSHCN SP staff partner with Baylor College of Medicine, the LEAH grantee for

Texas, on a variety of initiatives. LEAH works to improve the health and well-being of adolescents through education, research, program and service model development, evaluation, and dissemination of best practices. CSHCN SP staff participates on the planning committee for and attends the LEAH Program's annual Chronic Illness and Disability Conference. Title V contracts with LEAH to provide: scholarships for family members of CYSHCN to attend the conference; one-month rotations of 12 internal medicine residents through a transition clinic for older teens and young adults with chronic diseases and disabilities; and implementation, and evaluation of an innovative electronic health record adolescent-to-adult health care transition template.

## COORDINATION WITH OTHER INITIATIVES

EPSDT -- DSHS administers preventive health services to Medicaid EPSDT eligible clients from birth through 20 years of age through the Texas Health Steps program. DSHS leadership uses the Medicaid Executive Management Team to ensure cross-agency communication, collaboration, and risk/issue management related to Medicaid Policy and Texas Health Steps. Title V staff are actively involved with HHSC in actions relating to the lawsuit concerning preventive services in Children's Medicaid (the Frew v. Suehs lawsuit) and provide support for the strategic initiatives that have been developed to improve direct care for children with Texas Health Steps/Medicaid coverage. Title V staff also partner with Texas Health Steps to develop on-line training modules free to all types of providers on a wide variety of child/adolescent health and safety issues and other professional development topics.

WIC -- Title V staff continue to collaborate with the federal Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), administered by DSHS, on breastfeeding promotion and other issues that enhance the health of their shared populations, such as tobacco cessation and promotion of physical activity and nutrition.

SSA -- CSHCN SP case management staff and contractors assist families in completing applications and obtaining disability determinations as needed in order that CYSHCN may access appropriate Social Security Administration (SSA) Supplemental Security Income (SSI) and other benefits. Children and youth eligible to receive SSI benefits in Texas receive health care benefits through Medicaid. CSHCN SP provides outreach to SSI eligible clients to determine the need for case management services. Additionally, it provides back-up, gap-filling health benefits coverage if a child receiving SSI loses Medicaid due to an extra SSI payment in a month. Vocational rehabilitation (VR) services for CYSHCN typically begin during the high school years as a complement to education transition services. Beginning at age 16, all children receiving special education services may receive transition vocational rehabilitation services through DARS. DARS has 100 Transition VR counselors co-located in schools all across Texas to facilitate providing these services. CSHCN SP staff collaborate on both state and local levels with DARS staff and educators throughout Texas to support transition of CYSHCN into post-secondary education, employment, and independent living.

Healthy Start -- Title V staff work collaboratively with the Texas Healthy Start Alliance to strengthen the efforts targeting the high risk populations that Healthy Start serves. The Healthy Start sites are working on a variety of population-based activities, including breastfeeding, immunization compliance, diabetes and risk factors of overweight/obesity, folic acid promotion, sexually transmitted infection prevention, early prenatal care social marketing campaigns, and car seat safety. Texas has six Healthy Start sites that are organized into a single Texas Healthy Start Alliance. The six sites in Texas are in Brownsville, Houston, Fort Worth, Dallas, Laredo, and San Antonio.

Rape Prevention Education -- Title V staff work on the CDC Rape Prevention and Education (RPE) grant. DSHS contracts with the Texas Office of the Attorney General's Sexual Assault Prevention and Crisis Services Program to implement this grant. These activities support the primary prevention of sexual assault and/or violence. The following activities are used to achieve the goals of the project: educational seminars, training programs for professionals, preparation of

information material, and education and training programs for students and campus personnel designed to reduce the incidence of sexual assault. Currently, the RPE Planning Team is in the process of implementing the CDC-approved State Plan for the Primary Prevention of Sexual Violence in Texas. This includes exploring ways to expand the prevention efforts beyond education and training to policy and environmental change.

Big 5 State Prematurity Collaborative -- Title V staff partner with the March of Dimes on the Big 5 State Prematurity Collaborative and with the Texas' Big 5 Quality Improvement Committee. The March of Dimes Big 5 State Prematurity Collaborative is exploring data-driven perinatal quality improvement through the development and adoption of evidence-based interventions and the data systems and tools required to track changes in specific perinatal issues and indicators in the nation's five biggest states (California, Florida, Illinois, New York, and Texas).

***//2013/ Healthy Texas Babies -- Title V staff oversee this new initiative to help Texas communities decrease infant mortality using evidence-based interventions. It involves community members, healthcare providers, and insurance companies. A reduction in preterm birth leading to lower infant mortality will improve the health of Texas babies and mothers and has the potential to save millions of dollars in healthcare costs. Activities include evidence-based interventions led by local coalitions, a communications campaign to raise public awareness of factors leading to infant mortality, health disparities, and preterm birth, surveys with data to help DSHS improve access to care, provider education, and increasing understanding of how to meet the needs of men in their roles as fathers and support father involvement. //2013//***

## **F. Health Systems Capacity Indicators**

For children, improvements in the State Health Systems Capacity Indicators based on provisional 2011 data are seen in the declining rate of children hospitalized with asthma (19.4 / 10,000); the increased percent of infants enrolled in Medicaid who received an initial periodic screen (94 %), the increased percent of six to nine year-old children on Medicaid who received dental care (75.8 %), and the increase in SSI beneficiaries under 16 who received services through the state CSHCN Program (33.7 %). There was a significant drop in the percentage of SCHIP-eligible infants receiving an initial screening because of a change in the CHIP Perinatal Program policy in 2010 that automatically moved infants under 185% FPL into the state Medicaid program. While there was no change in eligibility criteria for Medicaid or CHIP since the last Title V Annual Report, the children who received a service who are potentially eligible for Medicaid decreased from 67.5 to 64.1 percent. The Texas Title V-funded programs and contractors continue to incorporate appropriate referral mechanisms into the existing Medicaid and CHIP systems to increase participation and utilization.

For pregnant women and infants, patterns from previous years continue to reflect that there is slightly higher percentage of low birth weight deliveries, higher rate of infant mortality, and lower percentages of prenatal care utilization in Medicaid-covered populations compared to non-Medicaid and the state as a whole. Following a 10-year trend, the 2010 overall infant mortality rate of 6.1 for Texas continues to be lower than the national rate. The Healthy Texas Babies initiative led by the Office of Title V and Family Health is poised to have a potentially positive influence on systems that will improve birth outcomes and reduce health disparities among the diverse population in the state.

A major state initiative that will potentially impact all of these indicators is the newly approved 1115 Medicaid waiver. The 2011 Texas Legislature directed the state's Health and Human Services Commission (HHSC) to expand managed care to achieve savings, and to preserve hospital access to funding consistent with upper payment limit (UPL) funding. HHSC concluded that the best approach to meet legislative mandates and to preserve funding, expand managed care, achieve savings, and improve quality was to negotiate a five-year 1115 waiver with CMS that was subsequently approved in December 2011.

In addition to expanding Medicaid managed care coverage to all 254 counties in the state, the Upper Payment Limit payment methodology will be replaced in state fiscal year 2013 with two funding pools -- the Uncompensated Care and Delivery System Reform Incentive Payment (DSRIP) pools. Uncompensated Care Pool Payments are designed to help offset the costs of uncompensated care provided by the hospital or other providers.

DSRIP Pool Payments are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In their leadership roles with DSHS, Commissioner David Lakey, M.D., and Deputy Commissioner Luanne Southern, M.S.W., were both invited to participate on the Clinical Champions Workgroup to assist in the technical development of an initial draft DSRIP menu of projects, milestones and metrics. Maternal and child health has been well represented in the planning efforts in this new and unique opportunity to improve quality of care and health outcomes at the community level.

Complete details and current updates on key dates and activities are available at the HHSC website: <http://www.hhsc.state.tx.us/1115-waiver.shtml>

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

At a time when budgets are constrained and resources are limited while the demand for services increases, priorities and performance measures guide Title V staff to focus program efforts and available resources on activities that are critical to improve the health and well-being of women and children in Texas. Along with the established outcome measures, performance measures ensure accountability, promote efficiency, and provide comparisons to other states. Together, the measures also provide both short-term goals and a long-term vision for maternal and child health in the state. Linking the two ensures that activities designed to advance the state toward meeting short-term performance goals will lay the foundation and initiate progress toward achieving long-term outcome measures for Texas and the nation.

As previously described, in conducting the FY11 Title V Five-Year Needs Assessment, DSHS made considerable efforts to ensure that stakeholder input was direct and inclusive of as many partners, providers, consumers, and other stakeholders interested and impacted by MCH issues as possible. The process incorporated a wide variety of methods and venues to gather input from and establish ongoing communication with stakeholders: community meetings, state-level meetings, group presentations, web-based surveys, facilitated exercises, email communication, newsletter articles, and website information.

The extensive stakeholder input process resulted in a ranked list of 24 recommended need statements. The Needs Assessment Planning Group reviewed the statements in the context of the quantitative data that was gathered and then consolidated them based on similarities of populations, services, or functions. Based on the themes that emerged, the group formulated 10 priority needs for the State of Texas. All three MCH populations are included in the new priorities and aspects of prevention, primary care, and services for CYSHCN have been woven throughout the set. The priorities focus on the areas of:

- Access to care across the life course,
- Mental health and substance abuse,
- CYSHCN transition,
- Dental care,
- Healthy child and adolescent development,
- Essential enabling services,
- CYSHCN community-based systems of care,
- Population-based health promotion and disease prevention,
- Health care provider workforce development and retention, and
- Evidence-based interventions.

Informed by these priorities, Title V staff, in partnership with other DSHS MCH-related program staff, revised state performance measures and developed FY11 activity plans to address the needs identified during the needs assessment process and continue work on improving the health and well-being of the MCH population. Throughout the project year, Title V staff will continue to work closely with DSHS staff from partnering programs to support the implementation of these planned activities and monitor progress towards meeting the FY11 performance goals.

The MCH service level pyramid guides Title V staff on how efforts are ideally proportioned across direct health care, enabling services, population-based services, and infrastructure building services to ensure that there is an appropriate balance of funds that reflect the different needs in Texas. Under the direct oversight of the State Title V Director, ongoing efforts to accurately track Title V expenditures using specific budget program codes that stratify services by population and pyramid service level have led to improved reporting and allocation planning. These efforts have also allowed for the opportunity to fund one-time projects, limited in scope and duration, to address immediate needs in the state with the confidence that by doing so the federally-required

funding expenditure allocations will not be compromised.

Outcome measures are another means to convey progress and accountability in achieving program goals. In FY09, Texas met three of the six national outcomes measures concerning fetal, infant, and child mortality. Those met included the postneonatal mortality rate per 1,000 live births, the perinatal mortality rate per 1,000 live births plus fetal deaths, and the child death rate per 100,000 children aged 1-14. The remaining three outcome measures were not met, although there was improvement in two. The two unmet but improved outcomes were the infant mortality rate per 1,000 live births and the neonatal mortality rate per 1,000 births. From 2005 to 2009, there was no change in the ratio of the Black infant mortality rate to the White infant mortality rate and a slight worsening in the ratio of the Black perinatal mortality rate to the White perinatal mortality rate. The indicators on infant mortality identify the challenge that Texas continues to face in reducing the mortality outcomes for infants less than 28 days of age, especially among Black infants. Since the research literature links these outcomes to maternal health and the adequacy of prenatal care, DSHS will continue to implement activities that target populations where these risk groups are most prevalent.

Title V services provided by DSHS are intended to promote health and well-being, as well as to positively affect the national outcome measures. While the affect of these activities on the outcome measures is often cumulative, descriptions of Texas' more immediate progress on the national and state performance measures are provided in this section under C. National Performance Measures and D. State Performance Measures.

## **B. State Priorities**

The FY11 Five-Year Needs Assessment stakeholder input process collected public comment that resulted in recommended needs statements for maternal and child health in Texas. The Needs Assessment Planning Group, including the Title V MCH and CSHCN Directors, reviewed the needs statements gathered and sorted them into groups based on similarities of populations, services, or functions, leading to a list of 10 priority needs. While there may be some concern that the new priorities are either too broad or cannot be solely addressed through the efforts of Title V funding, they are meant to serve as a framework that can be used as a consistent guide for the future. The department's ability to respond to the rapidly-changing health care environment requires broad vision and flexibility. The state priorities easily can be linked to the four service levels of the MCH services pyramid: Direct, Enabling, Population-Based, and Infrastructure Building. All three MCH target populations are included in the priorities and aspects of prevention, primary care, and services for CYSHCN have been woven throughout the set.

The 10 Texas Title V priorities and their associated MCH pyramid level and performance measures are discussed below. The order of the items is not a ranking by importance, as all are considered of equal value. For reference, the FY11 National and State Performance Measures (NPM/SPM) are:

NPM 1 -- The percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

NPM 2 -- Percent of CSHCN (0-18 yrs) whose families partner in decision making at all levels and are satisfied with services they receive.

NPM 3 -- Percent of CSHCN age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home.

NPM 4 -- Percent of CSHCN age 0-18 whose families have adequate private and/or public insurance to pay for the services they need.

NPM 5 -- Percent of CSHCN age 0-18 whose families report the community-based systems are organized so they can use them easily.

NPM 6 -- Percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

NPM 7 -- Percent of 19-35 mo. olds who have received full schedule of age appropriate immunizations against MMR, Polio, Diphtheria, Tetanus, Pertussis, HIB and Hep B.

NPM 8 -- Rate of birth (per 1,000) for teenagers aged 15 through 17 years.

NPM 9 -- Percent of 3rd grade children who have received protective sealants on at least one permanent molar tooth.

NPM 10 -- Rate of deaths to children aged 14 yrs and younger caused by motor vehicle crashes per 100,000 children.

NPM 11 -- Percentage of mothers who breastfeed their infants at six months of age.

NPM 12 -- Percentage of newborns who have been screened for hearing before hospital discharge.

NPM 13 -- Percent of children without health insurance.

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

NPM 15 -- Percentage of women who smoke in the last three months of pregnancy.

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

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

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

SPM 1 -- Change in percentage of CYSHCN living in congregate care settings as percent of base year 2003.

SPM 2 -- Rate of excess fetio-infant mortality in Texas.

SPM 3 -- The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.

SPM 4 -- The percent of women between the ages of 18 and 44 who are current cigarette smokers.

SPM 5 -- The percent of obesity among school-aged children (grades 3-12).

SPM 6 -- Rate of preventable child deaths (0-17 year olds) in Texas.

SPM 7 -- The extent to which research findings and/or evidence-based practices are used to develop and improve DSHS programs serving MCH populations.

**PRIORITY: SUPPORT AND DEVELOP HEALTH CARE INFRASTRUCTURE THAT PROVIDES COORDINATED ACCESS TO SERVICES IN A CULTURALLY COMPETENT MANNER, ADDRESSING HEALTH ISSUES ACROSS THE LIFE COURSE (Direct & Infrastructure Building).**

During the stakeholder input process for the FY11 Five-Year Needs Assessment, the most frequently mentioned needs were those pertaining to access to coordinated, holistic health care for the MCH population. Texas has one of the highest percentages of uninsured children in the nation. According to the Texas Office of the State Demographer, there were approximately 1.5 million, or 24%, of the population birth to 17 years of age who were uninsured in 2010. Nearly two-thirds of Texas' uninsured children come from low-income families who may be eligible for CHIP or Medicaid. Additionally, 36.5% of women of childbearing age (18 to 44 years) reported they had no health care coverage and 30.4% reported not seeing a doctor due to cost. Challenges with accessing health care services may contribute to the percent of low birth weight babies (8.5% in 2006), the percent of infants born preterm (13.6% in 2006), and the rate of infant mortality (6.2 infant deaths per 1,000 live births in 2006).

PMs related to this priority: NPMs 3, 4, 5, 13, 17, 18, and SPM 2

**PRIORITY: INCREASE THE AVAILABILITY OF QUALITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (Direct & Infrastructure Building).**

Mental health counseling and other related services are important resources for many women and children in Texas. Research confirms that women suffer from depression and depressive symptoms more frequently than men. They also seek out mental health services more often than men. Findings from the 2007 Texas Behavioral Risk Factor Surveillance System (BRFSS) Survey showed that approximately one in five women of childbearing age reported that they felt sad, blue, or depressed on one or more of the preceding 30 days while 23% reported that a mental illness or emotional problem kept them from doing their work or usual activities.

Many children struggle with emotional or behavioral problems. According to the National Survey of Children's Health (NSCH), among Texas children 2 to 17 years of age, 2.4% are currently diagnosed as developmentally delayed with a condition that affects their ability to learn. The 2005/2006 NS-CSHCN reports that 3.1% of CSHCN in Texas have ongoing emotional, developmental, or behavioral conditions. Furthermore, many children and adolescents who need mental health counseling do not receive it. The 2007 NSCH reports that in Texas, 4.7% children and adolescents received counseling from a mental health professional in the past year, yet 12.2% have an unmet need related to mental health care.

PMs related to this priority: NPMs 3, 4, 5, 6, 15, 16, and SPMs 3, 4

**PRIORITY: INCREASE THE NUMBER OF YOUTH WITH SPECIAL HEALTH CARE NEEDS WHO RECEIVE NECESSARY SERVICES TO TRANSITION TO ALL ASPECTS OF ADULT LIFE (Enabling).**

Successful transition to all aspects of adult life lays a foundation for long-term individual and family physical and mental health and wellness. Federal laws require that transition formally be addressed in both education and vocational rehabilitation. Often times health care transition, which, at minimum, involves changing from pediatric to adult providers and includes having the knowledge and skills to manage one's own care and adequate resources to pay for care, is overlooked by providers and families alike. From the 2005-2006 NS-CSHCN, 37.1% of Texas CYSHCN (13 to 17 years of age) receive the services necessary to make transitions to all aspects of adult life.

PMs related to this priority: NPM 6

**PRIORITY: INCREASE ACCESS TO DENTAL CARE (Direct & Infrastructure Building).**

According to the National Survey of Children's Health, 78.4% of Texas children saw a dentist for preventive care within the past 12 months. There are several reasons why many women do not visit a dentist or take their children to a dentist. Among women in Texas with incomes below \$25,000 a year, barriers to receiving dental care are cost (62.5%), no reason to go (13%), dentist does not accept my insurance, (3%), fear or nervousness (2%), and no appointments available (1%).

Within the last 12 months, 20.2% of Texas CYSHCN needed preventative dental care, and did not get it. Poor and uninsured children, children with lapses in insurance, and children with greater limitations had greater unmet dental care needs. In keeping with the acknowledged benefits of having a medical home, children with a personal doctor or nurse were less likely to have unmet dental care needs.

In 2010, 117 of Texas' 254 counties were determined to have too few dentists with more than 15 million (62%) Texans residing in these counties.

PMs related to this priority: NPMs 3, 4, 5, 9

**PRIORITY: SUPPORT COMMUNITY-BASED PROGRAMS THAT STRENGTHEN PARENTING SKILLS AND PROMOTE HEALTHY CHILD AND ADOLESCENT DEVELOPMENT (Enabling & Population-Based).**

According to the 2007 results from the Youth Risk Behavior Survey, Texas youth are at greater risk than youth across the US to engage in behaviors that contribute to the leading causes of death, disability, and social problems. This priority supports a comprehensive, evidence-based youth development approach to increase healthy behaviors and decision-making among Texas youth.

Additionally, this priority supports the value of fully incorporating the needs and knowledge of the family and of the child/adolescent into decision making throughout the service system. This includes active family participation in policy making for both local service delivery and state service systems. Providers serving children and adolescents, including CYSHCN, should recognize the importance of forming partnerships with families and learn about families' cultural norms, preferences, expectations, and needs.

PMs related to this priority: NPMs 2, 5, 14, and SPMs 1, 5, 6

**PRIORITY: SUPPORT THE DEVELOPMENT OF COMMUNITY-BASED SYSTEMS THAT PROVIDE ESSENTIAL ENABLING SERVICES NEEDED TO IMPROVE HEALTH STATUS (Enabling & Population-Based).**

Having community-based systems that provide culturally-appropriate, supportive social services necessary to enable families not only to access health care, but also to maintain follow-up care is critical to improving health status among the MCH population. Access to information regarding health and human services programs, transportation assistance, low-cost medications, affordable child care, and comprehensive case management services were all identified as needs in the FY11 Five-Year Needs Assessment.

PMs related to this priority: NPM 5 and SPMs 1, 3

**PRIORITY: IMPROVE THE ORGANIZATION OF COMMUNITY-BASED SYSTEMS OF CARE FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (Enabling & Infrastructure Building).**

Community-based systems that are organized so that families of CYSHCN can use them easily are dependent not only on the availability of services, but also on their proximity and the means by which they are delivered. It includes such considerations as whether information about health and human services programs is easily understood and readily available; comprehensive case management services are available; programs are streamlined, comprehensive, coordinated and culturally competent; family support services such as respite, and home or vehicle modifications can be obtained easily; and families are satisfied with the services and supports they receive.

In Texas, the NS-CSHCN showed that the percent of CYSHCN whose families report that community-based service systems are organized so they can use them easily rose from 76.8% in 2001 to 88.2% in 2005-2006.

PMs related to this priority: NPM 5 and SPM 1

**PRIORITY: USE POPULATION-BASED SERVICES INCLUDING HEALTH PROMOTION AND DISEASE PREVENTION INTERVENTIONS TO IMPROVE HEALTH OUTCOMES OF THE MCH POPULATION (Population-Based).**

This priority is broadly stated in order to accommodate a variety of needs identified during the FY 11 Five-Year Needs Assessment process. These needs encompassed all types of population-based education and systems change needs involving topics such as immunizations, breastfeeding, obesity, violence prevention, teen pregnancy, and environmental contaminants.

PMs related to this priority: NPMs 1, 5, 7, 8, 10, 11, 12, 14, 18, and SPMs 2, 3, 4, 5, 6

**PRIORITY: ENSURE ALL CHILDREN, INCLUDING CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS, HAVE ACCESS TO A MEDICAL HOME AND OTHER HEALTH CARE PROVIDERS THROUGH INCREASED TRAINING, RECRUITMENT, AND RETENTION STRATEGIES (Infrastructure Building).**

The combined diversity of Texas' demography and geography creates challenges related to adequate access to health services. Sparsely populated areas experience challenges in recruiting and retaining health professionals. Furthermore, supply shortages are not limited to rural areas. Some inner-city areas include pockets of shortage designation areas where primary care is unavailable as well. Moreover, the number of providers may appear adequate in these areas, but access is limited based on non-acceptance of Medicaid or a patient's inability to pay for services.

In 2010, of the total 254 Texas counties, 189 counties were recognized as having too few primary care physicians including family practitioners, general practitioners, pediatricians, internists, or obstetrician/gynecologists; 117 were recognized as having too few dentists; and 194 were recognized as having too few mental health providers.

Additionally, in the 2005-2006 NS-CSHCN, 46.3% of Texas CYSHCN families indicated they receive coordinated, ongoing, comprehensive care within a medical home. This is less than the comparable 47.1% nationally, and less than the number reported in the 2001 NS-CSHCN.

PMs related to this priority: NPM 3

**PRIORITY: PROMOTE THE EXPANSION OF NEW OR EXISTING EVIDENCE-BASED INTERVENTIONS TO ADDRESS MATERNAL AND CHILD HEALTH NEEDS (Infrastructure Building).**

In recent years, there has been increased interest concerning the effectiveness and accountability of prevention and intervention programs. The increased demand for program quality, and evidence of that quality, has resulted in the need to identify and implement evidence-based programs. Evidence-based programs are those where evaluation studies, subjected to

critical peer review, have documented that the positive results can be attributed to the intervention itself, rather than to outside events. Efforts to incorporate evidence-based strategies when working with MCH populations can positively impact Title V state and national performance and outcome measures.

PMs related to this priority: SPM 7

/2012/ Some indicators previously reported for 2008 and 2009 changed significantly in the Block Grant Application for 2011 due to the availability of more current data. Vital statistics data included in the previous application was final through 2006. As such, indicators reported for 2007 and beyond were projections based on linear trends. In the current application, vital statistics data is final through 2008 and provisional data is available for 2009. Additionally, indicators using 2010 population projections as a denominator are likely to be overestimated as current population estimates developed through 2009 using actual records have revealed that population projections for 2010 may be an underestimate. //2012//

### C. National Performance Measures

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

#### Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	433	470	524	554	571
Denominator	433	470	524	554	571
Data Source		Newborn Screening Database	Newborn Screening Database	Newborn Screening Database	Newborn Screening Database
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

#### Notes - 2011

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

#### Notes - 2010

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

**Notes - 2009**

Denominator is number of confirmed cases as indicated on Form 6. In the previous application, the 2009 number of confirmed cases included all types of Galactosemia. This number has been adjusted to include confirmed cases of only classical-type Galactosemia, as directed by the Block Grant guidance.

**a. Last Year's Accomplishments**

Activity 1: There were 384,007 initial newborn screening specimens with 1,889 (0.49%) found unsatisfactory. There were 11,390\* contacts made for unsatisfactory specimens. Education materials distributed included 120 Weight Conversion Charts, 198 Specimen Collection Guides, 136 Spot Check Guides, 19 sets of ACT / FACT sheets, 74 Newborn Screening Specimen Submitter Packets, 38 CD Slide Presentations, and 116 Neonatal Screening brochures.

\*Some contacts are regarding multiple specimens for one submitter and some specimens require multiple contacts made to one submitter.

Activity 2: Education efforts included distribution of 130,269 Newborn Screening Program (NBS) Brochures, 187 NBS posters, and 1,894 bookmarks. In addition 5,189 Sickle Cell Trait Letters and 5,189 information booklets were mailed. There were 586,430 web based encounters. 1,344\* providers accessed NBS online education modules. There were 858 new web-based system users added for NBS online services.

\*Figure includes Newborn Screening providers and other health care professionals who accessed and completed Newborn Screening, Sickle Cell Disease and Trait, and Sickle Cell Trait education modules.

Activity 3: The Information for Parents of Newborns booklet was posted online and available in print in both Spanish and English formats. 147,612 of the print booklet were distributed in English and 62,178 were distributed in Spanish. The booklet was also downloaded from the DSHS website 2,615 times in English and 1,457 times in Spanish. Parents and providers can e-mail [infoforparents@dshs.state.tx.us](mailto:infoforparents@dshs.state.tx.us) with questions about the booklet.

Activity 4: The Texas Newborn Screening Performance Measures Project ended in August 2011. The pre-Analytical Universal Report card was fully developed and will undergo data validation and testing in FY12. The team tested a web-based application of the report card. There were delays in fully implementing the performance measure due to budget and staffing shortages; however, the project team remained committed to the new performance measure launched in January 2011.

Performance Assessment: NBS met the annual objective of 100% follow up and case management of identified presumptive positives. This was accomplished with continued increased awareness of the legal requirements for NBS and continued technical assistance to minimize the number of unsatisfactory tests.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures.			X	
2. Educate parents and health professionals about newborn screening benefit, state requirements, and importance of follow-			X	

up to positive tests.				
3. Promote the prenatal distribution of Information for Parents of Newborns to provide parents with information about SIDS prevention, immunizations, shaken baby syndrome prevention, postpartum depression, newborn screening, and other important resourc			X	
4. Implement identified measures that link the quality of patient care with the quality of pre and post-analytical stages of the newborn screening process.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: There were 190,165 initial newborn screening specimens with 1,192 (.63%) found unsatisfactory. 8,322\* contacts were made to submitters with unsatisfactory specimens. Education materials distributed included 154 Weight Conversion Charts, 107 Specimen Collection Guides, 46 Spot Check Guides, 11 sets of ACT / FACT sheets, 68 Newborn Screening Submitter Packets, 23 CD Slide Presentations, and 52 Neonatal Screening brochures.

\*Some contacts regarding multiple specimens for one submitter and some specimens require multiple contacts made to one submitter.

Activity 2: Education efforts included distribution of 60,362 NBS brochures, 533 NBS posters, and 3,262 bookmarks. 2,576 Sickle Cell Trait Letters and brochures were mailed. There were 165,632 web-based encounters. 553 NBS providers and other health care professionals accessed and completed NBS, Sickle Cell Disease and Trait, and Sickle Cell Trait education modules. 474 new users were added.

Activity 3: The Information for Parents of Newborns is available online and in print in English and Spanish. The mailbox remains available for questions.

Activity 4: Performance measures have been developed for both pre and post-analytical phases of the newborn screening (NBS) system. A Report Card was developed to provide feedback to healthcare submitters on their pre-analytical and post-analytical practices. The Laboratory is finalizing a web based application to offer easy online access to the monthly Report Cards.

***An attachment is included in this section. IVC\_NPM01\_Current Activities***

**c. Plan for the Coming Year**

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

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

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

Activity 2: Educate parents, including expectant parents and parents of newborn children, and health professionals about newborn screening benefit, state requirements, and importance of follow-up to positive tests by distributing brochures on newborn screening to health care providers, providing Information for Parents of Newborn Children pamphlets for distribution by health care providers and facilities to all expectant and postpartum parents, placing information regarding newborn screening on the NBS Program website, and making an e-mail address available for any questions regarding newborn screening.

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

Monitoring: Document distribution of materials and interactions with stakeholders.

Activity 3: Promote the prenatal distribution of Information for Parents of Newborns to provide parents with information about SIDS prevention, immunizations, shaken baby syndrome prevention, postpartum depression, newborn screening, and other important resources.

Output Measure(s): Brochure available in English and Spanish, on the MCH webpage, and in hard copy.

Monitoring: Ensuring posting of brochure on website and notification/distribution to key stakeholders.

Activity 4: Implement identified measures that link the quality of patient care with the quality of pre-analytical stages of the newborn screening process.

Output Measure(s): Establish evidence-based best practices in the areas of pre-analytical stages of the newborn screening process that will serve as a model for nationwide replication; investigate and document specific interventions and tools for which there is evidence or a demonstrable likelihood of effectiveness in improving performance/ quality in areas with noted deficiencies.

Monitoring: Measures will be tracked using statistical reports from the Laboratory Information Management System (LIMS).

### Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	<b>384085</b>							
<b>Reporting Year:</b>	<b>2011</b>							
<b>Type of Screening Tests:</b>	<b>(A) Receiving at least one Screen (1)</b>		<b>(B) No. of Presumptive Positive Screens</b>		<b>(C) No. Confirmed Cases (2)</b>		<b>(D) Needing Treatment that Received Treatment (3)</b>	
	No.	%	No.	No.	No.	%		
Phenylketonuria (Classical)	379255	98.7	56	4	4	100.0		

Congenital Hypothyroidism (Classical)	379255	98.7	7442	212	212	100.0
Galactosemia (Classical)	379255	98.7	201	6	6	100.0
Sickle Cell Disease	379255	98.7	183	153	153	100.0
Biotinidase Deficiency	379255	98.7	671	64	64	100.0
Cystic Fibrosis	379255	98.7	315	59	59	100.0
Homocystinuria	379255	98.7	122	0	0	
Maple Syrup Urine Disease	379255	98.7	81	1	1	100.0
Tyrosinemia Type I	379255	98.7	1	0	0	
Argininosuccinic Acidemia	379255	98.7	97	0	0	
Citrullinemia	379255	98.7	0	2	2	100.0
Isovaleric Acidemia	379255	98.7	445	1	1	100.0
Methylmalonic Acidemia	379255	98.7	381	3	3	100.0
Propionic Acidemia	379255	98.7	0	2	2	100.0
Carnitine Uptake Defect	379255	98.7	446	3	3	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	379255	98.7	134	5	5	100.0
Multiple Carboxylase Deficiency	379255	98.7	0	1	1	100.0
long-Chain Hydroxyacyl-CoA Dehydrogenase Deficiency	379255	98.7	35	1	1	100.0
Trifunctional Protein Deficiency	379255	98.7	0	0	0	
Glutaric Acidemia Type I	379255	98.7	185	1	1	100.0
Hydroxymethylglutaric Aciduria	379255	98.7	0	0	0	
Congenital Adrenal Hyperplasia (Classical)	379255	98.7	4140	24	24	100.0
Medium Chain Acyl-CoA Dehydrogenase Deficiency	379255	98.7	202	23	23	100.0
Very-Long-Chain Acyl-Co A Dehydrogenase Deficiency	379255	98.7	121	4	4	100.0
Methylmalonic Acidemia (mutase deficiency form)	379255	98.7	0	1	1	100.0
Beta-Detothiolase Deficiency	379255	98.7	0	1	1	100.0
Hearing Screening	2564289		42150	0	0	
Vision Screening	2638853		216326	0	0	
Spinal Screening	725505		23200	0	0	

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	57.5	58	58.1	58.2	58.3
Annual Indicator	57.9	57.9	70.3	70.3	70.3
Numerator	450786	450786	639197	639197	639197
Denominator	778339	778339	908622	908622	908662
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	72	72	74	74	75

**Notes - 2011**

For 2011-2014, indicator data are from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing errors.

**Notes - 2010**

Indicator data are from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2009**

Indicator data are from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

**a. Last Year's Accomplishments**

Activity 1: CSHCN SP contractors, central office, and regional staff attended numerous stakeholder meetings with participation by family members and monitored family listserv postings to identify emerging and unmet needs. Key areas of interest for families included the state budget shortfall, outcomes of the legislative session, access to community services including respite and pediatric specialists, guardianship, special education, affordable health care, and people first

respectful language.

CSHCN SP contractors hosted conferences, workshops, support groups, parent advisory groups, and information fairs, including Spanish-language programming and services for fathers. Contractors distributed resource materials, loaned durable medical equipment, assisted with basic needs, and provided supplies, medications, and respite to families with CYSHCN, including those on military bases.

CSHCN SP contractor, Texas Children's Hospital, continued its family-centered wellness program for CYSHCN to educate and empower families and youth on obesity prevention. Methods included facilitated play and integrated learning to convey the importance of good nutrition and physical fitness.

A Title V and Baylor College of Medicine's Leadership Education in Adolescent Health (LEAH) partnership provided stipends for 47 families and youth/young adults with disabilities to attend the annual LEAH transition conference.

TxP2P created a Neonatal Intensive Care Unit (NICU) Network to facilitate parent to parent support for families with children in NICUs and initiated plans to partner with NICUs to promote and expand the program.

CSHCN SP staff and Medical Home Workgroup (MHWG) members guided the Emergency Medical Services for Children (EMSC) State Partnership toward improvements in delivery of pediatric services in the community. EMSC initiatives included collaborative research, evidence-based pediatric protocol for EMS providers, and pediatric equipment on ambulances.

CSHCN SP staff presented at the Children's Special Needs Network family conference and the TxP2P annual conference on Consumer Directed Services, opportunities for inclusion and making friends outside the classroom, and health care transition. Conference evaluations indicated satisfaction with content.

Activity 2: CSHCN SP staff gauged family satisfaction with contracted services and obtained input for improvement utilizing a survey with standardized core questions. 1,530 family surveys were evaluated; 1,507 (98.5 %) reported overall satisfaction with contractor services; 1,500 (98.0%) were satisfied with access to services and information; 1,508 (98.6%) were satisfied with customer service; and 1,495 (98%) were satisfied with family involvement in planning, delivery, and decision making.

Activity 3: As a follow-up to the FY11 Title V Needs Assessment, CSHCN SP stakeholder satisfaction surveys were distributed by contractors to individuals and at group meetings. Surveys were collected through February 28, 2011. A delay in data entry prevented reporting results in FY11; however, comparison to previous data will be made in FY12 with results reported for future program planning and decision making.

CSHCN SP staff participated in the development of a comprehensive online survey for the Task Force for Children with Special Needs. Input was obtained from children and families through the survey, public hearings, and comments at Task Force meetings. Input was used in developing recommendations and a Five-Year Strategic Plan to improve the service system and address priorities for families and children.

Performance Assessment: The 2009/10 NS-CSHCN reported 70.3 % of Texas families of CYSHCN aged 0-18 feel they are partners in decision making and are satisfied with services they receive. Texas was on par with the national average. The measure was not comparable across survey years due to changes in survey questions. CSHCN SP contractor client/family surveys consistently reported high levels of overall satisfaction with services. DSHS sought family input and participation in decision making through stakeholder meeting reports, contractor reporting,

parent focus groups, surveys, parent conferences, and collaboration with Family Voices representatives.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote and support family input and partnership in decision-making at state, local, and individual levels of service planning and delivery.				X
2. Monitor consumer satisfaction with CSHCN Services Program (SP) contractor services.				X
3. Assess consumer needs and satisfaction pertaining to health care benefits and state service systems.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: CSHCN SP contractors and central office and regional staff attended 136 stakeholder meetings with participation by 2,532 family members. Priority concerns included difficulty navigating complex systems, finding pediatric specialists, and scarce respite resources.

Staff met with TxP2P staff and received updates about AMCHP Family Scholar activities. Staff attended HHSC’s Council on Children and Families and received parent/stakeholder input concerning needs of foster children, children with intellectual disabilities, and increasing positive behavioral supports programs.

Contractors participated in local activities including health fairs, school events, and CRCG meetings. They sponsored conferences, workshops, and information fairs for CYSHCN families.

CSHCN SP Contractor, Coalition of Health Services, was honored by the Panhandle Area Health Education Center as a Rural Health Champion at the National Rural Health Day Celebration for work supporting rural health care and education in the community.

Activity 2: 733 family surveys were evaluated. 726 (99%) reported an overall satisfaction rate of contractor services; 726 (99 %) are satisfied with access to services and information; 726 (99 %) are satisfied with customer services; and 722 (98% %) are satisfied with family involvement in planning, delivery, and decision-making.

Activity 3: CSHCN SP staff began developing a survey to assess family satisfaction with services and care in the health care benefits program.

***An attachment is included in this section. IVC\_NPM02\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Promote and support family input and partnership in decision making at state, local, and individual levels of service planning and delivery.

Output Measure(s): Monitoring documentation of key CYSHCN family stakeholder groups;

documentation of staff and contractor participation in stakeholder groups with CYSHCN family membership; documentation of training and other efforts to promote family involvement and partnership in decision making at state, local, and individual levels, documentation of contractor collaboration and coordination.

Monitoring: Information from Stakeholder Meeting Records, regional meeting/events, contractor quarterly reports and conference calls, Information & Referral (I & R) provided to non-clients, and program discussions concerning family input in decision making and activity planning. Staff reporting of training and other efforts.

Activity 2: Monitor CYSHCN family satisfaction with CSHCN SP contractor services.

Output Measure(s): Indicators of level of satisfaction with CSHCN SP contractor services; contractor quarterly satisfaction survey results and the percentage of CYSHCN families who are satisfied with services they receive; priority concerns/suggestions relevant to CYSHCN from contractor conference calls, Quality Assurance (QA) site monitoring visits, and quarterly reports; recommendations/input to contractors from CYSHCN families and contractor response to this feedback.

Monitoring: Review contractor quarterly reports and QA site monitoring visits.

Activity 3: Review and evaluate CYSHCN needs and satisfaction pertaining to health care benefits and state service systems as reported by available data.

Output Measure(s): Consumer satisfaction assessment activities implemented, data analysis, and recommendations made/actions taken based on results from stakeholder meeting records, focus groups, listening sessions, and surveys.

Monitoring: Satisfaction assessment efforts, progress, barriers, and results.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	58.8	46.4	46.5	46.6	46.7
Annual Indicator	46.3	46.3	40.1	40.1	40.1
Numerator	351768	351768	355285	355285	355285
Denominator	759974	759974	886995	886995	886995
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016

Annual Performance Objective	42	43	44	45	46
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**Notes - 2011**

For 2011-2014, indicator data are from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing errors.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Numerator and denominator are weighted estimates.

**a. Last Year's Accomplishments**

Activity 1: The MHWG met quarterly with active discussion of activities, initiatives, and updates to the strategic plan that were documented in meeting minutes. Specific presentations included Emergency Medical Services for Children, the THSteps online provider education module, "Introduction to Medical Home," and an update on a project started with Title V funding. The project supported medical home practices resulting in obtaining National Committee for Quality Assurance (NCQA) Patient Centered Medical Home certification for 18 clinics in the Trinity Mother Frances Hospital System.

The DSHS Commissioner convened a committee of medical directors from private and public health insurance providers to discuss common health care delivery issues. Members joined the MHWG to collaborate and more effectively work to address medical home issues related to health insurance.

CSHCN SP staff finalized and submitted a CYSHCN impact statement and worked collaboratively on the Task Force for Children with Special Needs' Five-Year Strategic Plan.

Two MHWG members, a physician and a parent, collaborated with others on an online article published in Pediatrics: "Clinical Report - Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home" in July 2011. A MHWG member was appointed by the Governor to the Medicaid Pharmacy and Therapeutics Committee which recommends the preferred drug list adopted by HHSC.

The CSHCN SP medical home website had 109,971 hits in FY11.

Activity 2: CSHCN SP contractors and regional staff assisted 1,037 families receiving case management in finding a medical home. 3,064 (95.6%) CYSHCN receiving case management had a primary care provider (PCP). Of the CYSHCN who had a PCP, 3,012 (98.6%) had seen

that PCP within the past 12 months.

Staff educated families and providers about medical home through contractor training, conferences, grand rounds, and medical residency programs. CSHCN SP staff served on the Traumatic Brain Injury Advisory Council to promote integration of medical home and mental health/behavioral health. TxP2P conducted a medical home survey and distributed a "Medical Home Toolkit" to increase understanding.

380 health care professionals completed the THSteps Medical Home online training module, which includes information on the National Committee for Quality Assurance (NCQA) Medical Home Recognition standards.

Activity 3: CSHCN SP staff participated in the Project Access Learning Collaborative funded by HRSA's MCHB. CSHCN SP staff developed a partnership with Texas Association of Community Health Centers to promote the goals of providing a comprehensive approach to coordinated and family-centered care for CYSHCN. Activities include monthly conference calls and surveys of Texas' FQHCs to determine medical home and care coordination gaps in services and training.

A major initiative is the continued partnership with the Baylor College of Medicine LEAH program. Title V funds facilitated increased access to coordinated and integrated care in a medical home for transitioning youth. LEAH supported 47 family members' participation in the annual transition conference. Outreach and recruitment contributed to increased attendance by youth from 6 to 13 participants and statewide participation with 35 participants from non-Houston areas. 36 of 47 participants completed the evaluation with an average of 88% positive response. Spanish language translation was provided.

Performance Assessment: The 2009/10 NS-CSHCN reported that 40.1% of Texas CYSHCN aged 0-18 years received coordinated, ongoing, comprehensive care within a medical home. This is somewhat below the nationwide average of 43.0% and a 6.2% decline from the data reported for Texas in 2005/06. However, the nationwide data also showed a decline of 4.1%. The Texas percent of CSHCN with a personal doctor or nurse increased from 91.5% in 2005/06 to 94.4% in 2009/10 while the nationwide percent declined. The reasons for the declines in the medical home summary measure are not readily apparent. Increasing awareness and access to a medical home continue to be priorities for CSHCN SP. The MHWG and major Texas initiatives increased awareness of the medical home concept for families, physicians, third party payors, state agency personnel, and others.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide leadership to and collaborate with the Medical Home Workgroup (MHWG) and others to increase awareness, knowledge, implementation of, and access to quality medical home practice and integrated dental and mental/behavioral health services.				X
2. CSHCN SP regional staff and contractors help CYSHCN access medical homes and integrated dental and mental/behavioral health services.		X		
3. Collaborate with the Medicaid Health Home Project and other initiatives to increase CYSHCN access to quality medical homes and integrated dental and mental/behavioral health services.				X
4.				
5.				
6.				

7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: The Medical Home Work Group (MHWG) met quarterly with active discussion of ongoing activities, initiatives, and updates to the strategic plan. Topics included the Blue Cross Blue Shield Texas Medical Home Pilot Project, Healthy Texas Babies Initiative, Raising Texas, Maternal and Child Health Home Visiting grant, LEAH Conference, and the parent-led Hali Project which trains "Parent Partners" to coordinate family-centered care in pediatric practices.

Activity 2: Contractors and regional staff assisted 494 families in finding a medical home. CSHCN SP staff serves on various statewide task forces and work groups to promote medical home. 343 contractors and other health care professionals completed the THSteps Introduction to the Medical Home training module.

CSHCN SP contractor, Scott & White, continued providing medical home supports to children served in their pediatric subspecialty clinics. Any Baby Can of Austin continued partnering with the Children's Health Express mobile clinic to provide a medical home for CYSHCN.

Activity 3: CSHCN staff participated in discussions with the Texas Children's Health Plan and TxP2P regarding a potential application for a state implementation grant for systems of services for CYSHCN with an emphasis on medical home. Staff participated in Healthy Texas Babies (HTB) Initiative activities to stress the importance of the medical home for infants and their families.

***An attachment is included in this section. IVC\_NPM03\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Provide leadership to and collaborate with the Medical Home Workgroup (MHWG) and others to increase awareness, knowledge, implementation of, and access to quality medical home practice and integrated dental and mental/behavioral health services.

Output Measure(s): Progress on MHWG strategic plan, MHWG minutes, input from MHWG members, reimbursement of providers for Clinician Directed Care Coordination; development of core health outcome measures for CYSHCN across state programs; documentation of number of persons completing the DSHS Introduction to Medical Home training module; articles published in the Family Newsletter; presentation schedule (conferences, seminars, and other venues); postings to primary websites - CSHCN SP, Texas page of AAP medical home, and other relevant websites; development and dissemination of materials/tools information.

Monitoring: Review MHWG meeting minutes, provider billing and reimbursement data, Task Force for Children with Special Needs meeting minutes, DSHS training module data, relevant publications, presentations, and staff activity documentation.

Activity 2: CSHCN SP regional staff and contractors help CYSHCN access medical homes and integrated dental and mental/behavioral health services.

Output Measure(s); number and percent of CYSHCN served by case management/clinical services contractors with a primary care physician (PCP) and who have seen that PCP in the past 12 months; number of CYSHCN assisted with establishing a medical home by regional staff and case management/clinical services contractors; staff and contractor activities to promote access to and integration of medical home, dental, and mental/behavioral health services; documentation of completion of the DSHS Introduction to Medical Home training module by

contractors.

Monitoring: Review regional activity and contractor quarterly reports, DSHS training module completion certificates submitted by contractors.

Activity 3: Collaborate with medical home projects and other initiatives to increase CYSHCN access to quality medical homes and integrated dental and mental/behavioral health services.

Output Measure(s): Documentation of the implementation and progress of medical home as a result of legislative, academic, or agency actions; documentation of the implementation and progress of other medical home initiatives, identifying any specific emphasis on integration of dental and mental health services.

Monitoring:

Review of medical home projects and other initiatives; activity and data reports.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	54.1	58.3	58.4	58.5	58.6
Annual Indicator	58.2	58.2	58.0	58.0	58.0
Numerator	462528	462528	520600	520600	520600
Denominator	795137	795137	898296	898296	898296
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	58.7	58.8	58.9	58.9	58.9

**Notes - 2011**

For 2011-2014, indicator data are from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing errors.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

#### **Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

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

Activity 1: CSHCN SP, Medicaid/CHIP, and Texas Medicaid Health Partnership (TMHP) initiated the Centralized Provider Enrollment Application Workgroup to implement provider screening criteria and other requirements of the Affordable Care Act (ACA). Staff continues to monitor ACA activities to assess impact.

CSHCN SP staff made recommendations for enhancements to the TMHP Online Provider Look-Up to facilitate ease of use, improved accuracy, and the opportunity to report system malfunctions.

HHSC submitted a proposal to the Centers for Medicaid & Medicare Services (CMS) to create a Section 1115 Demonstration Waiver allowing for the expansion of managed care throughout the state while maintaining historic supplemental Medicaid funding to hospital providers. The proposal included a provision to develop a dental managed care model for primary and preventative services for children age 20 and under.

HHSC introduced a new system that uses digital technology to streamline the Medicaid verification process. Plastic cards replaced paper identification letters allowing providers to determine eligibility instantly and to access health history. HHSC redesigned its CHIP/Children's Medicaid website to support enrollment, enhance the site's community outreach section, and also updated application forms with simplified language.

Enrollment in the Youth Empowerment Services (YES) pilot, a Medicaid waiver program that provides intensive community-based services and supports for children with serious emotional disturbances and their families, was slower than anticipated. Limitations on mental health and substance abuse treatment benefits in both Medicaid managed care and CHIP were dropped to meet terms of the Mental Health Parity and Addiction Equity Act of 2008.

Reduced funding for ECI resulted in increased family co-pays and narrowing eligibility criteria.

Activity 2: During FY11, 1,872 children received CSHCN SP health care benefits. As of August 31, 2011, 1,549 children were on the waiting list for health care benefits due to funding limitations. Of these children, 679 had no other health care coverage. CSHCN SP assisted 29 families with insurance premium payments. Staff promoted enrollment of FQHCs and therapists as providers. CSHCN SP contractors and regional staff assisted families with CHIP, Medicaid, and CSHCN SP applications to prevent coverage lapses.

CSHCN SP staff, DSHS regional social workers, and TMHP improved the process to assist eligible clients acquire health coverage under Emergency Medicaid which resulted in savings for CSHCN SP.

Activity 3: CSHCN SP provided stipends for 47 family members to attend the Baylor College of Medicine's LEAH conference. CSHCN SP staff and community-based contractors facilitated conference webcasts at multiple Texas sites allowing for more stakeholders and family members to learn about accessing health care for their youth aging out of pediatrics into adult health care.

The CSHCN SP Family Newsletters and Provider Bulletins included articles on choosing doctors,

getting needed medicines, Medicaid Buy-In for Children (MBIC), and accessing Emergency Medicaid.

CSHCN SP staff made presentations to DSHS regional social workers and contractors on the MBIC application process and its potential impact for some children receiving CSHCN SP health care benefits. Quarterly meetings of the CSHCN SP's Transition Team and Medical Home Workgroup featured presentations on MBIC. Staff and contractors exhibited at conferences and responded to inquiries about Medicaid/CHIP, Medicaid Waivers, MBIC, and CSHCN SP benefits to help families and providers access resources.

Performance Assessment: In the 2009/10 NS-CSHCN, 57.9% of Texas CSHCN aged 0-18 reported having adequate private and/or public insurance to pay for needed services. Texas fell slightly below the national average of 60.6%. This is consistent with 2005/06 data.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pursue opportunities to collaborate with Texas Medicaid, CHIP, and other payers to maximize health care coverage, evidence-based practices, and quality outcomes for CYSHCN.				X
2. Maximize the provision of CSHCN SP health care benefits to eligible clients, pay insurance premiums when cost-effective, increase the number of providers, and monitor waiting lists.	X	X	X	X
3. Provide information to families, providers, and others on paying for health care for CYSHCN.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: CSHCN SP continued identifying services payable through retroactive emergency Medicaid to maximize the number of CYSHCN receiving health care benefits. Draft revisions of CSHCN SP rules were posted to the website for comment.

Texas received approval from the Centers for Medicare and Medicaid Services for a Section 1115 waiver allowing for Medicaid managed care expansion. Establishment of regional partnerships to promote health care improvements is a key component.

Activity 2: During the 1st half of FY12, 1,465 children received CSHCN SP health care benefits. As of February 29, 2012, 802 children were on the waiting list for these benefits. Of these children, 524 had no other health care coverage. CSHCN SP assisted 25 clients with insurance premium payments. DSHS regional staff and CSHCN SP contractors assisted families with CHIP, Medicaid, and CSHCN SP applications to access benefits and prevent coverage lapses.

Activity 3: The DSHS Oral Health Branch Manager, who serves as the State Dental Director, presented at the LEAH conference and educated participants on key issues surrounding payment for dental services for youth and adults with special health care needs.

The CSHCN SP Family Newsletter featured an article, "Tips for Choosing a Doctor." A quarterly contractors' conference call included a presentation by HHSC staff on the statewide dental

managed care initiative.

**An attachment is included in this section. IVC\_NPM04\_Current Activities**

**c. Plan for the Coming Year**

Activity 1: Pursue opportunities to collaborate with Texas Medicaid, CHIP, and other payers to maximize health care coverage, evidence-based practices, and quality outcomes for CYSHCN.

Output Measure(s): Documentation of collaborative activities regarding health care coverage, evidence-based practices, and quality measurement and outcomes of these activities, e.g. collaboration regarding Medicaid and federal health care reform initiatives.

Monitoring: Information on progress made through collaborative efforts, ongoing federal health care reform developments, and Texas Medicaid managed care expansion activities; assessment of impact for CYSHCN families.

Activity 2: Maximize the provision of CSHCN SP health care benefits to eligible clients, pay insurance premiums when cost-effective, increase the number of providers, and monitor waiting lists.

Output Measure(s): Number of CYSHCN eligible for CSHCN SP health care benefits including those receiving ongoing services, on the waiting list, who received CSHCN SP health care benefits, on the waiting list with no other source of insurance, and removed from the waiting list; number of CYSHCN families receiving CSHCN SP health care benefits that received Insurance Premium Payment Assistance (IPPA); number of CYSHCN families provided home or vehicle modifications through the CSHCN SP FSS; documentation of efforts to increase number of CSHCN SP providers and outcomes of those efforts.

Monitoring: Review monthly CSHCN SP health care benefits client and provider data from TMHP and program quarterly data summary reports.

Activity 3: Provide information to families, providers, and others on paying for health care for CYSHCN.

Output Measure(s): Articles published in CSHCN SP Family Newsletter, provider notices, and other publications; information posted on CSHCN SP website; informational materials shared with staff, contractors, or other means.

Monitoring: Review contractor quarterly reports, program publications, and other means of communication.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	77.3	88.3	88.4	88.5	88.6
Annual Indicator	88.2	88.2	56.6	56.6	56.6
Numerator	706914	706914	515491	515491	515491
Denominator	801141	801141	910457	910457	910457

Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	60	60	62	62	65

**Notes - 2011**

For 2011-2014, indicator data are from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing errors.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. Numerator and denominator are weighted estimates.

**a. Last Year's Accomplishments**

Activity 1: Finding Help in Texas, the 2-1-1 website received 284,564 hits relevant to Maternal and Child Health. CSHCN SP contractor, Coalition of Health Services, participated in a regional 2-1-1 Resource Conference. CSHCN SP website usage data showed the site was accessed 396,493 times.

Activity 2: CSHCN SP staff participated in planning for the Take Time Texas website scheduled to launch in FY12 to help families find respite resources and provide support for caregivers. Staff represented the interests of CSHCN and families on workgroups including the Children's Policy Council, Task Force for Children with Special Needs, Texas Respite Coalition, and Consumer Directed Services Workgroup.

TxP2P was awarded a five-year grant by The Texas Council for Developmental Disabilities to create a statewide disability advocacy network. TxP2P, the Emergency Medical Services Corporation (EMSC), and Houston Community College presented, "Assessment and Management of Children with Special Health Care Needs," offering an opportunity to learn from

CYSHCN and their families about the unique challenges of communication, unfamiliar technology, and family-centered assessment and management of CYSHCN in emergency situations.

Health care professionals completed CYSHCN-relevant THSteps training modules: 787 Case Management, 375 Mental Health Screening, and 531 Mental Health and Emotional Health and Behavior Disorders.

Activity 3: The People First Respectful Language bill was signed into law requiring the use of respectful, person first language (PFL) and began the process of replacing "mental retardation" with "intellectual disability" in state policies and statutes. CSHCN SP utilizes PFL, appropriate literacy levels, and Spanish translation in communication with contractors, providers, and stakeholders.

Staff met with the HHSC's Center for Elimination of Disproportionality and Disparities (CEDD) to forward the interests of children with disabilities and special health care needs in CEDD initiatives.

A total of 1,793 health care professionals completed the THSteps Cultural Competency module.

Activity 4: CSHCN SP health care benefits, contractors, and regional staff provided case management, family supports, and community resources to 21,397 clients.

Activity 5: Staff held quarterly conference calls with contractors to provide support, share success stories, and exchange ideas. Topics included Person-Directed Planning, Medicaid Buy-In for Children, supporting siblings, and a summary of the 82nd legislative session and its impact on CYSHCN. Staff presented workshops on maximizing opportunities for inclusion in after school activities, mental health, transition, and other Title V priorities. Contractors facilitated family support groups, participated in CRGs, and partnered with education service centers to co-sponsor events. CSHCN SP contractor, Paso del Norte, expanded its Leadership Academy for families with a focused curriculum for parents of children with mental health diagnoses.

Staff supported and coordinated contractors via ongoing technical assistance, site visits, and other quality assurance activities.

With Title V funding, Texas collaborated with Tulane University and University of Texas at Austin to provide Early Childhood Mental Health web-based training to over 40 licensed clinicians in Texas and to develop a Texas-specific training that allows clinicians continued access to evidence-based trainings focusing on early identification and treatment of children ages 0-5.

CSHCN SP developed announcements and provided letters of support for HRSA's Innovative Evidence-Based Models Grant. The Program nominated an affiliate of TxP2P who was selected as an AMCHP Family Scholar.

Performance Assessment: The 2009/10 NS-CSHCN indicated 56.6% of Texas families of CYSHCN aged 0-18 reported community-based services are easily accessed. This is less than the national average of 65.1% and significantly less than the 2005/06 state average of 88.2%. The 2009/10 NS-CSHCN questions were revised extensively; therefore, none of the three rounds of this survey are comparable. CSHCN SP staff and contractors continued efforts to improve easy access to community-based services through collaboration with other state and local partners. Client/family surveys in FY11 consistently reported high levels of satisfaction with case management, clinical services, and family supports and community resource services

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Collaborate with Texas Information and Referral/2-1-1 system to foster and improve effective awareness and linkage to community services and supports for CYSHCN and their families.				X
2. Participate in inter-agency, intra-agency and community efforts to assess and improve state policies, programs, and activities that affect CYSHCN and their families.				X
3. Enhance and promote the use of "People-First" language and use of appropriate languages, literacy levels, and cultural approaches in all communications regarding CYSHCN and their families.			X	
4. Provide comprehensive case management, family supports, and community resources through the CSHCN SP.		X		
5. Promote collaboration, training and professional development opportunities related to the Title V performance measures for providers, clients, families and others.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: Over 125,961 calls were made to the 2-1-1 system related to MCH.

Activity 2: Staff represented the interests of CYSHCN and families on workgroups including the Task Force for Children with Special Needs, Children's Policy Council, Consumer Directed Services Workgroup, and Texas Respite Coalition.

Staff initiated collaboration with the NBSU to help families access services and supports more quickly and easily.

Over 680 health care professionals completed the THSteps Case Management Services module.

Activity 3: Staff presented on People-First language at the 2011 Central Texas Network for Children with Special Needs Conference.

Staff reviewed and provided input to HHSC's draft guidelines for implementing People First Respectful Language subsequent to passage of the new state law.

CSHCN SP contractor, Paso del Norte, participated in the effort to change the name of their local advisory committee to remove outdated terminology. They also hosted a meeting to promote collaboration with families and ensure services are accessible and culturally sensitive to the border community.

A total of 1,480 health care professionals completed the THSteps Cultural Competence.

Activity 4: CSHCN SP contractors and regional program staff provided case management, family supports, and community resources to 7,683 clients.

Activity 5: Staff conducted conference calls, provided technical assistance, and prepared and presented on CSHCN SP Title V initiatives at conferences.

***An attachment is included in this section. IVC\_NPM05\_Current Activities***

### **c. Plan for the Coming Year**

Activity 1: Collaborate with Texas Information and Referral/2-1-1 system and others to improve awareness, emergency preparedness, and links to community services and supports for CYSHCN families.

Output Measure(s): 2-1-1 service requests related to Maternal and Child Health, efforts to maintain and increase 2-1-1 family resources, and increase 2-1-1 staff understanding of CYSHCN issues; documentation of emergency preparedness activities; documentation of information and referrals from regional staff and contractors;

Monitoring: Review quarterly 2-1-1 and other reports and collaborative efforts.

Activity 2: Participate in agency and community efforts to assess and improve state policies, programs, and activities impacting CYSHCN families.

Output Measure(s): Groups in which staff and contractors actively participate; review of stakeholder meeting records and reports to identify key issues, emerging/unmet needs, recommendations, and inform Title V activity planning; completion of the DSHS case management training module by staff, contractors, and others.

Monitoring: Review stakeholder meeting records, contractor quarterly reports, publications, annual Title V Activity Plan, and DSHS training module data.

Activity 3: Promote use of "People-First" language and appropriate languages, literacy levels, and cultural approaches in all communications regarding CYSHCN families.

Output Measure(s): Use of and efforts to promote "People First" language and appropriate literacy levels in publications, website content and interactions with stakeholders; bilingual publications; completion of the DSHS cultural competency training module by staff, contractors, and others.

Monitoring: Review media, staff activities, DSHS training module completion data, contractor technical assistance, Quality Assurance (QA) site visits, communications, and quarterly reports.

Activity 4: Provide and monitor comprehensive case management, family supports, and community resources through the CSHCN SP.

Output Measure(s): Number of CYSHCN receiving case management, family supports and community resources from contractors, regional staff, and health care benefits; QA activities.

Monitoring: Review contractor and regional quarterly reports, health care benefits FSS data, and contractor conference calls, quarterly meetings with regional staff, technical assistance, and site visits.

Activity 5: Promote collaboration, training, education, and professional development opportunities related to the Title V performance measures for providers, clients, families and others.

Output Measure(s): Contractor information sharing during contractor conference calls to promote innovation and best practice; technical assistance and training provided for relevant groups.

Monitoring: Review contractor conference call minutes, training, education, technical assistance efforts, and resource development.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	5.8	37.2	37.3	37.4	37.5
Annual Indicator	37.1	37.1	35.4	35.4	35.4
Numerator	107424	107424	101253	101253	101253
Denominator	289879	289879	286298	286298	286298
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	37.6	37.7	37.8	37.9	37.9

**Notes - 2011**

For 2011-2014, indicator data are from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing errors.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the

sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Numerator and denominator are weighted estimates.

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

Activity 1: CSHCN SP contractors and regional staff provided transition case management for 1,784 CYSHCN, including both medical and non-medical services. Support activities included sharing resources, updating website information, developing and publishing articles in family and provider publications, and attending or presenting at state and regional conferences or trainings. 323 professionals completed the THSteps Case Management Transition module. CSHCN SP staff distributed transition informational items to 275 individual case managers and others throughout the state.

Activity 2: CSHCN SP provided funding for 47 families, including 13 youth, to attend the 2010 LEAH annual conference in Houston. CSHCN SP staff helped plan the LEAH conference, the TxP2P Annual Conference, and the transition "Teen Summit" held during the TxP2P Annual Conference. Teen Summit participants included youth both with and without disabilities. Staff presented, "Advocacy Everywhere," with emphasis on self-advocacy in health care settings. CSHCN SP staff was the health care team lead on the Transitioning Youth Subcommittee of the Task Force for Children with Special Needs, coordinated planning activities, and prepared the narrative for the Five-Year Strategic Plan. Regional staff participated in area transition events in Amarillo, Houston, the Rio Grande Valley, and El Paso. Central office staff also exhibited at a "Destination Fair" sponsored by Central Texas area high schools and presented, "Which Agency Does What and Transition Self-Advocacy," for the Youth Leadership Forum held at St. Edwards University in Austin.

Activity 3: CSHCN SP staff convened quarterly meetings and revised the Transition Team Staff Support procedure. The Transition Team received and exchanged information about upcoming events and best practices. Informational program topics included the Partnership for Progress Medicaid Waiver Conference, Medicaid Buy-In, an overview of supported employment services, and higher education for students with intellectual disabilities. The Team reviewed and endorsed the transition section of the FY11 Title V Activity Plan.

Activity 4: CSHCN SP staff engaged stakeholders, made presentations, led or participated on state and regional-level work groups to advance transition promising practices, and updated the CSHCN SP Transition website. Presentations for educators and parents include Texas Transition Conference, Region XI Education Service Center; for professionals at the Houston Medicaid Forum; for students and professionals at the Texas School Social Workers Conference; and parents and professionals at the TxP2P Annual Conference.

State and regional-level work groups included the Task Force for Children with Special Needs, Community Resource Coordination State Work Group, Texas Council for Developmental Disabilities, Region XIII Education Service Center Transition and 18+ Networks, and the DARS Central Texas Transition Forum. Staff also participated in a stakeholder event concerning the TEA State Performance Plan transition and related indicators.

CSHCN SP renewed the LEAH contract for families attending the annual conference, transition training for residents, and a pilot to test an electronic medical record transition template. 14 agencies statewide helped recruit LEAH transition conference family participants, and 15 internal medicine residents completed a one-month transition clinic rotation. 13 clinics and 34 physicians enrolled in the transition template pilot.

Performance Assessment: The 2009/10 NS-CSHCN showed that 35.4% of Texas CYSHCN received necessary services for a successful transition to adult life. This is a reduction from the 37.1% reported in the 2005/06 NS-CSHCN, but is similar to the reduction shown in the nationwide data: from 41.2% in 2005/06 to 40.0% in 2009/10. Reasons for this reduction are not immediately clear. While the nationwide data shows a 2.6% increase in number of youth ages 12-

17 from 2005/06 to 2009/10, the Texas data shows a 2.5% decrease.

Transition continues to be a priority for CSHCN SP. Themes from stakeholders informed CSHCN SP planning. Efforts were ongoing to improve transition case management, offer more information and training opportunities for families and professionals, collaborate with education and rehabilitation partners, and participate in state-level transition forums. DSHS and families of CYSHCN benefited due to partnering with LEAH and other projects.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide transition case management for CYSHCN through CSHCN SP regional staff and contractors.		X		
2. Partner with youth and adults with special health care needs, their families, and others to share information and advise the CSHCN SP about transition activities.				X
3. Lead the PHSU Transition Team, including CSHCN SP staff and contractors, to coordinate and enhance CSHCN SP transition activities.				X
4. Contribute to or provide leadership, including training, to promote best and promising practices and to improve access to transition services and adult-serving providers in partnership with the LEAH program and other stakeholders.				X
5.				
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**b. Current Activities**

Activity 1: So far, 136 health care professionals completed the THSteps Case Management Transition module. CSHCN SP regional staff and 11 contractors provided transition case management for 978 CYSHCN and their families to gain access to needed medical, social, education, and other services.

Activity 2: CSHCN SP staff worked with youth, family members, and high school educators. CSHCN SP staff or contractors participated in transition fairs held in Austin, Amarillo, Midland, Round Rock, and at the Texas School for the Deaf. Staff partnered with parents to begin planning the 2012 TxP2P Annual Conference and Teen Summit.

Activity 3: The Transition Team met quarterly and discussed transition topics and professional development. Topics included Person-Centered Planning (presented by a parent), Disability Disclosure in the Workplace, and recent legislation. Team members exchanged ideas and updates on statewide events.

Activity 4: CSHCN SP funded 36 families, including 7 youth to attend the 2011 LEAH Conference. 36 people including family members also attended via remote site telecast. Staff and family members helped evaluate the 2011 conference and began planning for 2012. CSHCN SP continued a LEAH contract for interns' transition training and a transition Electronic Medical Record template. Staff presented at the Texas School Nurses Association, Education Service Center XIII, and the Texas Transition Conference.

***An attachment is included in this section. IVC\_NPM06\_Current Activities***

**c. Plan for the Coming Year**

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

Output Measure(s): Resources provided to regional staff and contractors regarding transition; utilization of online or other transition case management training; number of CYSHCN receiving individual transition services from CSHCN SP contractors and regional staff.

Monitoring: Review transition training data; quarterly regional and contractor case management reports.

Activity 2: Partner with youth and adults with special health care needs, their families, and others to share information and advise the CSHCN SP about transition activities.

Output Measure(s): Youth, adult, and family advisors identified and input/guidance received on transition activities; Texas Education Agency (TEA) post-school outcomes survey of young adults recently separated from public special education services.

Monitoring: Review progress and results reports.

Activity 3: Lead the PHSU Transition Team, including CSHCN SP staff contractors and non-contractor regional youth or family member representatives to coordinate and enhance CSHCN SP transition activities.

Output Measure(s): Progress reports; transition team activities, products, and results; contacts with contractors and others to discuss transition activities, exchange information, and provide technical assistance to promote successful practices.

Monitoring: Review meeting minutes, publications, and progress reports, including contractor reports.

Activity 4: Contribute to or provide leadership, including training, to promote best and promising practices and improve access to transition services and adult-serving providers in partnership with transition projects and other stakeholders.

Output Measure(s): Distribution of and updates to resource information; utilization of and updates to CSHCN SP web site transition page; information shared with CYSHCN, families, providers, and others via publications/presentations; information reported at and outcomes or results from transition-related interagency and other meetings attended; participation in planning and attendance at meetings or conferences; identification of and contacts with adult-serving providers.

Monitoring: Review resource information shared, trainings developed, meeting minutes, stakeholder meeting records, and reports of other collaborative efforts.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>

Annual Performance Objective	80	80	80	81	80
Annual Indicator	78.2	78.6	74.4	76.3	75.5
Numerator	427369	431060	412459	430989	405448
Denominator	546507	548422	554380	564742	537302
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	77	77	79	79	80

**Notes - 2011**

The percent immunized are from the National Immunization Survey <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart> (accessed on 03/25/2011). Data from 2006-2010 are final.

2010 numerator data was received from the CDC's request form, as this particular immunization calculation is no longer reported on their website.

2011 numerator data is a projection based on 2006-2010.

2011 denominator based on population projections for 2011 from CHS.

**Notes - 2010**

Updated June 2012: 2010 data are now final (non-projected).

The percent immunized are from the National Immunization Survey <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart> (accessed on 03/25/2011). Data from 2006-2009 are final. Numerator data for 2010 is a linear projection using NIS data from 2002 through 2009. Denominator data is a 2010 population projection from the Texas Office of the State Demographer.

**Notes - 2009**

This indicator has been adjusted for final data. The percent immunized are from the National Immunization Survey <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart> (accessed on 03/25/2011). Data from 2006-2009 are final.

**a. Last Year's Accomplishments**

Activity 1: 51 local health department contractors with the DSHS Immunization Branch identified 94 partnerships with stakeholders, including independent school districts, Head Start programs, Immunization Coalitions, hospitals, local Red Cross organizations, fire departments, community health advisory boards, the Zapata Colonias Stakeholders Committee at the Mexican Consulate, and a local college. Activities included community planning, immunization clinics, and education/training on vaccination requirements both for children and adults, especially first responders.

Activity 2: In FY11, 51 local health department contractors with the DSHS Immunization Branch provided training and technical assistance on the use of ImmTrac, the Texas state immunization registry 928 times. They also conducted trainings and provided technical assistance on the Vaccines for Children program 1,162 times.

Performance Assessment: Projected numbers indicate a slight decrease in the number of 19-35 month olds who have received a full schedule of age appropriate immunizations. Activities continue to identify and develop partnerships, both internally and externally with stakeholders, to raise vaccine coverage levels. Training continues to promote ImmTrac and the Vaccines for Children program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.				X
2. Through provider and public training, technical assistance and education, promote the use of the state immunization registry, ImmTrac and the Vaccines for Children program.			X	
3.				
4.				
5.				
6.				
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**b. Current Activities**

Activity 1: The 50 local health department contractors with the DSHS Immunization Branch in FY12 identified 74 partnerships with stakeholders, including independent school districts, Head Start programs, Immunization Coalitions, hospitals, local Red Cross organizations, fire departments, community health advisory boards, pharmacies, local supermarkets, and colleges. Activities included community planning, immunization clinics, education/training on vaccination requirements both for children and adults, especially cooperation with community colleges and other colleges to help meet the newly passed requirements for bacterial meningitis vaccine. TISWG met on December 8, 2011 with more more than 70 participants to discuss the new bacterial meningitis vaccine requirements for students at institutions of higher education in Texas.

Activity 2: The 50 local health department contractors with the DSHS Immunization Branch

provided training and technical assistance on the use of ImmTrac, the Texas state immunization registry, a total of 401 times by mid FY 12. They also conducted trainings and provided technical assistance on the Vaccines for Children program 632 times.

**An attachment is included in this section. IVC\_NPM07\_Current Activities**

**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(s): Number and types of partnerships; summary report on efforts undertaken; current initiatives and outcomes or expectations.

Monitoring: Track the number and type of partnership activities.

Activity 2: Through provider and public training, technical assistance and education, promote the use of the state immunization registry, ImmTrac and the Vaccines for Children program.

Output Measure(s): Number of state, regional, and local activities that promote participation in the state immunization registry, ImmTrac and the Vaccines for Children program; number of materials produced.

Monitoring: Track number and type of activities, including quarterly Health Service Region reports; documentation on materials produced.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	37	32	32	32	34
Annual Indicator	34.9	34.9	33.1	29.2	27.2
Numerator	18449	18934	17907	16015	14015
Denominator	528403	542343	540995	547814	515779
Data Source		Natality Data and Office of State Demographer			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average					

number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	26	26	26	25.5	25.5

**Notes - 2011**

2011 birth data is provisional & subject to changes.  
 2011 population data based on population estimates from Texas State Demographer.

**Notes - 2010**

Update June 2012: Natality data for 2010 is finalized.

Denominator data is projected by the Office of the State Demographer.

**Notes - 2009**

Update: 2009 Data has been finalized.

Denominator data provided by the Office of the State Demographer.

**a. Last Year's Accomplishments**

Activity 1: DSHS received funding for the Abstinence Education Program (AEP) from the Administration for Children and Families (ACF). DSHS submitted the state abstinence plan and released a RFP for the AEP for which 7 new contractors were selected to serve Bexar, Tarrant, Travis, Dallas, and Smith counties. Contractors began their planning and implementation phase, such as training in evidence-based curricula including Promoting Health Among Teens, Draw the Line/Respect the Line, Project AIM, Making a Difference, and ESTEEM. Contractors completed assessments of community services in regards to teen pregnancy prevention in their areas.

Activity 2: DSHS Adolescent Health and HIV/STD Prevention staff trained stakeholders on positive youth development and the link to sexual risk taking behaviors. Six presentations on the Texas Teen Opportunity Project were made at 3 conferences, including American Public Health Association, Maternal and Child Health Epidemiological Conference and Healthy Teen Network. Over 7,100 professionals, community members, and parents received information on the prevention of sexual risk taking behaviors and teen pregnancy prevention through presentations, workshops and other awareness activities by the school health specialists. Local teen pregnancy prevention coalitions in El Paso and Hidalgo counties met quarterly to continue strategic planning to address teen pregnancy. The Rio Grande Valley Coalition, comprised of approximately 95 members representing over 65 different organizations throughout the Rio Grande Valley area, organized to create an awareness of teen pregnancy and the implications it has for the future of the Valley youth. The Coalition hosted a Stay Teen Day targeting teen issues and concerns such as mentoring, sex education, volunteering, college preparedness, and other teen-generated issues. The El Paso County Teen Pregnancy Prevention Coalition, consisting of approximately 137 members representing 30 organizations, met quarterly for both their large group meetings as well as coordination meetings. Through various task forces, the Coalition began collecting information on available programs and resources in the area, assembling local sexually

transmitted infection and pregnancy data, and participated in the second annual Stay Teen Day event to promote abstinence and other healthy choices to at risk youth in the area.

DSHS and the Texas Education Agency published and distributed the 2009 Texas Youth Risk Behavior Survey Summary databook.

Activity 3: Power2Wait toolkits (154) were distributed to 34 schools, 2 churches, and 16 youth organizations. 16 Youth Leadership Clubs were created.

Approximately 35 youth and adult sponsors, who have participated in Texas Youth Leadership Clubs (TYLCs) throughout the year, attended The Extreme Youth Leadership Training, August 2-5, 2011, at Schreiner University in Kerrville, TX. Participants returned to their communities with action plans to work on throughout the next year.

Activity 4: DSHS regional staff attended over 300 meetings to share teen pregnancy prevention data or participate in activity planning or implementation with schools districts, School Health Advisory Councils, Teen Pregnancy Prevention Coalitions, and other community partners. Programs or activities included promotion of evidence-based teen pregnancy prevention programs, youth development, risk reduction and positive behavioral approaches.

Activity 5: Six contractors received training and technical assistance from DSHS and the State Adolescent Health Resource Center on using a developmental approach to adolescent health to influence change in communities. Contractors have been implementing strategic plans, focusing on training community members in building assets in young people, building capacity of organizations on effective youth-adult partnerships, and creating youth-friendly and focused communities. Two communities submitted applications to America's Promise to be designated as one of America's 100 Best Communities for Young People. The applications highlighted the work through their local Healthy Adolescent Initiative as being the driving force for seeking this designation. Youth are becoming involved in local program and policy development as a result of local partnerships and training.

Performance Assessment: Following national trends, adolescent birth rates showed larger declines as compared to previous fiscal years and may be due to numerous socio-ecological factors.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase opportunities to engage in teen pregnancy prevention activities at the state and local levels.				X
2. Coordinate educational and awareness activities to increase understanding of teen pregnancy prevention, including disparities (racial/ethnic, geographic) in rates.			X	
3. Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent adolescent pregnancy.				X
4. Coordinate and implement regional and local teen pregnancy prevention activities.			X	
5. Implement Texas Healthy Adolescent Initiative in local communities.				X
6.				
7.				
8.				
9.				

10.				
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**b. Current Activities**

Activity 1: The Texas YRBSS data were received from the CDC in October 2011. DSHS is examining the data to identify behaviors that may be associated with early childbearing and those that relate to positive development. The Texas School Health Network (TSHN) and Health Service Region staff participated in local teen pregnancy prevention activities and provided training and support to local coalitions, providers, school districts, and other community members.

Activity 2: El Paso and Hidalgo county coalitions continued strategic planning on adolescent pregnancy and included 39 community partners to help plan local teen pregnancy prevention community activities.

Abstinence-Centered Teen Pregnancy Prevention Program (ABC) contractors implemented evidence-based curricula in 7 counties, serving 2,522 youth aged 10-13 years, 642 youth aged 14-16 years, and 355 parents. These programs incorporate the Texas Youth Leadership Clubs service learning projects.

Power2Wait toolkits (37) were distributed to school districts and community organizations. Over 7,100 brochures and workbooks were distributed.

Activity 3: The six THAI sites completed and are disseminating media projects. Topics included healthy relationships, communication, education, reframing the perception of youth, and other asset building topics. The media projects were created, produced and led by youth, making the projects relevant to youth in each of the communities.

***An attachment is included in this section. IVC\_NPM08\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Coordinate educational and awareness activities to increase understanding of teen pregnancy prevention, including disparities (racial/ethnic, geographic) in rates.

Output Measure(s): Number, type, and format of activities implemented, including presentations, written materials; number and type of activities coordinated by or implemented by Health Service Region Staff.

Monitoring: Copy of materials or products distributed; summary of annual events; review quarterly progress reports.

Activity 2: Partner with external and internal stakeholders to engage in teen pregnancy prevention activities at the state and local levels, and create opportunities for innovative interventions to prevent early child-bearing.

Output Measure(s): Number of meetings and types of partners engaged; developed proposals for implementation; number and type of abstinence-centered program activities, including direct service contracts, and parent, school and community resources; number of youth (age 17 and under) receiving family planning services.

Monitoring: Review meeting notes; quarterly progress reports.

Activity 3: Implement and evaluate THAI in local communities.

Output Measure(s): Number of contractors; number and type of activities conducted by contractor. Number of best practices identified through the evaluation

Monitoring: Documentation of materials and plans developed; monthly progress reports.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	35	34.4	37	37	37
Annual Indicator	22.7	34.4	34.4	34.4	34.4
Numerator	72898	122241	126694	129149	130514
Denominator	321135	355351	368296	375432	379400
Data Source		Texas Education Agency	Texas Education Agency	Texas Education Agency	Texas Education Agency
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	37	39	39	39	39

**Notes - 2011**

The 2007/2008 Texas Basic Screening Survey was used to estimate the percent of 3rd grade students who had protective sealants on at least one permanent molar. The numerator is estimated by applying this percent to the total number of 3rd grade students in Texas for 2011 (Source: Texas Education Agency; <http://www.tea.state.tx.us/student.assessment/reporting/>).

It is anticipated that Texas will conduct the next Basic Screening Survey in the 2012-2013 school year.

**Notes - 2010**

The 2007/2008 Texas Basic Screening Survey was used to estimate the percent of 3rd grade students who had protective sealants on at least one permanent molar. The numerator is estimated by applying this percent to the total number of 3rd grade students in Texas for 2010 (Source: Texas Education Agency; <http://www.tea.state.tx.us/student.assessment/reporting/>).

It is anticipated that Texas will conduct the next Basic Screening Survey in the 2012-2013 school year.

**Notes - 2009**

The 2007/2008 Texas Basic Screening Survey was used to estimate the percent of 3rd grade students who had protective sealants on at least one permanent molar. The numerator is estimated by applying this percent to the total number of 3rd grade students in Texas for 2009 (Source: Texas Education Agency; <http://www.tea.state.tx.us/student.assessment/reporting/>).

**a. Last Year's Accomplishments**

Activity 1: The DSHS Oral Health Program (OHP) provided dental sealants to 3,683 children through program specific school-based dental sealant efforts and/or through collaborations with academic, community and faith-based organizations during FY11. This represents 35.1% of the 10,489 children screened during FY11.

Activity 2: Of the 10,489 children screened, 808 (7.7%) had a treatment urgency of 2 and 3,065 (29.2%) had a treatment urgency of 1. The remaining 7,995 children (76.2%) had no visible signs of untreated decay. The data collected was convenience data, not representative of the state. It showed oral health improvement when compared to recent statewide Basic Screening Survey data.

Activity 3: DSHS OHP provided screening services to 10,489 children in school-based and Head Start clinics through program specific efforts and collaborations with academic, community and faith-based organizations.

Activity 4: The State Dental Director worked with HHSC and THSteps to review provider education training modules. Three posters promoting oral health preventive messages were developed, printed, and available for ordering online through the THSteps website. The posters support provider understanding and implementation of the First Dental Home (FDH) and Oral Evaluation and Fluoride Varnish (OEFV) in the Medical Home services. The posters have been distributed to THSteps providers and other community-based partners through exhibits at professional dental meetings and Medicaid dental stakeholder's forums. DSHS regional staff promoted online trainings addressing FDH, OEFV, Oral Health Examinations by Dental Professionals, and Oral Health for Primary Care Providers.

DSHS regional staff activities related to children's oral health focused on increasing staff knowledge through completion of online training modules developed by the Oral Health Program for Texas Health Steps.

Performance Assessment: Data indicates that the number of 3rd grade children receiving a protective sealant on at least one permanent molar continues to grow in proportion to the number of 3rd graders in Texas. Collaboration continues with public elementary schools, Head Start programs, dental professionals, and local health departments in rural and underserved areas to promote dental sealant use.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue providing dental sealants to Texas school children.	X			
2. Monitor data on the number and percent of third graders with untreated caries.				X
3. Increase access to preventive dental care services through school-based efforts.				X
4. Collaborate with stakeholders to develop oral health promotion activities and materials for providers and recipients of services.			X	
5.				
6.				
7.				

8.				
9.				
10.				

**b. Current Activities**

Activity 1: The DSHS OHP regional dental teams provided limited oral evaluations to 6,025 children. Of these children, 2,271 (37.7%) were provided dental sealants through school-based and Head Start preventive dental services (PDS) projects.

Activity 2: DSHS OHP regional dental teams identified 1,803 (30%) children with untreated caries through limited oral evaluations provided during school-based and Head Start PDS projects.

Activity 3: DSHS OHP regional dental teams provided limited oral evaluations to 6,025 children, of which 1,803 (30%) of the children were referred for follow up dental care. Additionally, 5,406 (89.7%) were determined program eligible and were provided access to dental services through school-based and Head Start PDS projects offered by the DSHS OHP regional dental teams.

Activity 4: DSHS OHP worked with Women, Infants, and Children's (WIC) staff as well as staff from the DSHS Diabetes Program and Texas Health Steps to identify opportunities to develop and/or update oral health promotion activities and/or materials, and distribute these to providers and recipients of services.

***An attachment is included in this section. IVC\_NPM09\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Continue providing dental sealants to Texas school children.

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

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

Activity 2: Monitor data on the number and percent of third graders with untreated caries.

Output Measure(s): Summary of representative sampling data from regional dentists and other entities.

Monitoring: Analyze, interpret and report on data collected.

Activity 3: Increase access to preventive dental care services through school-based efforts.

Output Measure(s): Number of screenings provided, referrals made, and children with access to dental services through school-based health centers.

Monitoring: Analyze, interpret, and report on data collected, review quarterly progress reports.

Activity 4: Collaborate with stakeholders to develop oral health promotion activities and materials for providers and recipients of services.

Output Measure(s): Number and type of stakeholders involved in developing activities; number and type of materials developed; number and type of activities coordinated by regional staff.

Monitoring: Review of materials developed and distributed, review of quarterly progress reports.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	5.1	4.7	4.7	4.6	4
Annual Indicator	4.9	3.5	3.4	3.0	2.9
Numerator	261	188	187	173	161
Denominator	5332129	5384151	5449069	5738590	5608144
Data Source		Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	2.8	2.8	2.7	2.7	2.6

**Notes - 2011**

2011 numerator is a linear trend based on 2002-2010 data (previous 9 years). At the time of filling out form 11 NPM 10, the death data did not have all ICD-10 codes filled in, so this projection was used.

**Notes - 2010**

June 2012: Mortality data for 2010 is final.

Denominator data is projected by the Office of the State Demographer.

**Notes - 2009**

Update: 2009 data has been finalized.

Denominator data provided by the Office of the State Demographer.

**a. Last Year's Accomplishments**

Activity 1: Six grantees across Texas were provided a total 4,705 child safety seats to distribute to low-income families through car safety seat checkups. Program partners provided 4,143 safety seat classes that distributed 1,376 child safety seats in FY11.

Activity 2: Safe Riders Child Passenger Safety (CPS) Technician Workshops were held in 6 cities and trained 71 students. Many of the sponsor agencies were successful in working with Safe Riders to provide support to families on safety seat information and check-up locations to keep children safe in their communities.

Activity 3: The Safe Riders program conducted 58 presentations in four cities at schools, community organizations, child care facilities, and workforce development fairs. Additionally, traffic safety information was provided to 1,359 participants, including parents, students, teen parents, and child care staff.

Activity 4: Many Texas Child Fatality Review Teams (CFRTs) worked on activities aimed at motor vehicle safety awareness and reducing child death in and around vehicles.

The Johnson County CFRT provided 22 presentations on a variety of safety issues to 7 area school districts reaching faculty, parents, and approximately 3,000 middle and high school students. Because of several teen deaths due to texting while driving, they have been particularly interested in presenting information about the risks of texting while driving.

The Panhandle CFRT partnered with the Panhandle Safe Kids Coalition to conduct activities designed to keep kids safe in and around vehicles, including multiple car seat checks and seat installations as well as fitting and distributing 500 bicycle helmets. They worked together to conduct Safety Fairs throughout the 26-county area, and featured demonstrations of safe operation of all-terrain vehicles and of a rollover demonstration.

The Hidalgo/Starr Counties CFRT conducted a child passenger safety seat clinic where they checked 29 vehicles and replaced 26 unsafe care seats with new ones. The South Texas Tri-County CFRT (Val Verde, Edwards and Kinney Counties) conducted six car passenger safety seat clinics and distributed and installed 65 new child passenger safety seats. They also had four press releases on use of bike helmets, preventing vehicular hyperthermia deaths, and wheel sport safety in their local newspaper.

The Colorado/Austin/Waller CFRT conducted training in Head Start facilities on car seat laws and preventing vehicular hyperthermia deaths, as well as child passenger safety seat clinics in two counties. This team, in conjunction with area police, conducted seat belt checks upon arrival and at pick-up at elementary, junior high and high schools in several districts. As a result of their seat belt use survey, tickets were issued on the spot, more education on seat belt use and car passenger safety was provided at the elementary school level, and several schools changed their procedures to ensure greater safety when children arrive and depart campuses.

Because Texas had the greatest number of vehicular hyperthermia deaths in the U.S. in 2011, there was a statewide effort to educate and prevent deaths of young children left in hot cars. The Never Leave Your Child Alone in a Car (NLYCA) coalition was formed, and many of the CFRTs joined the coalition and conducted activities in their local communities. Among the teams locally addressing vehicular hyperthermia were Nacogdoches County CFRT, Wharton County CFRT, Hill Country CFRT and Taylor County CFRT. In the summer, training workshops for CFRT members were conducted in each of the DSHS Health Service Regions. In the training sites (Amarillo, Arlington, McAllen, Nacogdoches, Odessa, Round Rock, San Antonio, and The Woodlands), 316

attendees received specific training from the NLYCA coalition on preventing vehicular hyperthermia.

Performance Assessment: Adjustments to population data were made due to updated census information, which again caused significant changes in rates from data reported in previous years. Rates of motor-vehicle related deaths among children remains below the annual performance objective. With recent laws requiring booster seats for children up to age 8, unless taller than 4'9", Texas will likely continue to see decreases in the motor-vehicle related deaths among this age group.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute child safety seats to low-income families via educational classes throughout the state.		X		
2. Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.			X	
3. Conduct traffic safety presentations throughout the state.			X	
4. Review of report on child deaths resulting from motor vehicle crashes and develop policy recommendations and activities aimed at reducing such deaths.				X
5. Conduct regional motor vehicle safety activities throughout the public health regions.			X	
6.				
7.				
8.				
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10.				

**b. Current Activities**

Activity 1: Safe Riders distributed 3,740 car seats through 6 local organizations to low-income families during safety seat checkups. Community program partners offered 466 educational classes and distributed 1,625 child safety seats.

Activity 2: Safe Riders scheduled CPS courses around Texas. Local agencies worked with Safe Riders after each completed course to provide ongoing assistance to families on safety seat information and check-up locations to keep children safe in their communities. One safety course has been completed.

Activity 3: DSHS staff made 10 presentations on traffic safety to 401 individuals, including teen parents, state agency staff, families, and other community groups.

DSHS regional staff participated in over 190 motor vehicle safety activities, including health fairs, car seat safety checks and distribution, and other safety activities through Injury Prevention Coalitions, school districts, and CFRTs. DSHS regional staff checked or installed over 500 car seats and distributed over 300 car seats.

Activity 4: SCFRT recommendations to the Governor & State Legislature included a ban on driver use of wireless device unless device is hands-free, the repeal of law allowing parent-taught driver education, and a statute to require parents/guardians to attend motor vehicle traffic hearings of minors.

***An attachment is included in this section. IVC\_NPM10\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Distribute child safety seats to low-income families via educational classes throughout the state.

Output Measure(s): Number of organizations that participate in the distribution and education program; the number of safety seats issued to participating organizations; and the number of safety seats distributed.

Monitoring: Maintain a current list of participating organizations; track the number of seats distributed to the organizations on an ongoing basis.

Activity 2: Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.

Output Measure(s): Number of CPS technician training courses per quarter; number of students per course; number of update/renewal classes for certified CPS technicians; number of students per update/renewal classes.

Monitoring: Track number of technician training courses (per calendar year); number of students per course; number of update/renewal classes per year; number of students per class.

Activity 3: Conduct traffic safety presentations throughout the state and health service regions.

Output Measure(s): Number of traffic safety presentations conducted; number of persons attending each presentation; number of child safety seat check activities; number of safety seat checks conducted/number of safety seats installed; number of motor vehicle safety activities.

Monitoring: Track progress of presentations conducted (per calendar year); quarterly progress reports from regional staff.

Activity 4: Review of report on child deaths resulting from motor vehicle crashes and develop policy recommendations and activities aimed at reducing such deaths.

Output Measure(s): Annual Child Fatality Review Team Report on child deaths that includes motor vehicle crash deaths and policy recommendations; CFRT involvement in motor vehicle safety awareness activities; training session(s) on reducing motor vehicle crash deaths and appropriate prevention strategies at CFRT Annual Conference.

Monitoring: Updates on child deaths, prevention and training activities, and potential recommendations at quarterly State Child Fatality Review Team Committee meetings.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	38.5	37	48.5	56	51
Annual Indicator	46.1	46.9	48.5	50.2	51.9
Numerator	182673	189896	194919	193678	195434

Denominator	396167	405242	401610	385746	376684
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	54	54	56	56	58

**Notes - 2011**

For 2008, 2009, 2010, and 2011 estimates are linear projections using data from the National Immunization Survey for 2002 through 2007. Denominator data are all live births. The estimate for 2011 is based on provisional 2011 data from CHS.

As per the NIS survey for 2011, 42.7% were women were reported to have breastfed their infants at 6 months of age. However, these estimates were based on population estimates for 2011. Combined data for NIS since 2007, not yet available.

**Notes - 2010**

For 2008, 2009, and 2010, estimates are linear projections using data from the National Immunization Survey for 2002 through 2007. Denominator data are all live births. The estimate for 2010 is based on a linear projection using natality data from 2002 through 2008. Numerator data are calculated by multiplying the percent from the National Immunization Survey and the total number of live births.

**Notes - 2009**

For 2008, 2009, and 2010, estimates are linear projections using data from the National Immunization Survey for 2002 through 2007. Denominator data are all live births and are provisional for 2009. Numerator data are calculated by multiplying the percent from the National Immunization Survey and the total number of live births.

**a. Last Year's Accomplishments**

Activity 1: The DSHS Position Statement on Infant Feeding, last revised in 1998, was updated and posted to the DSHS website. WIC breastfeeding trainers completed a train-the-trainer course with 28 new Peer Counselor Trainers. New breastfeeding materials were produced. DSHS staff participated in state and national breastfeeding coalition meetings/phone conferences. Information was shared via state and national conferences, professional meetings, webinars, DSHS leadership meetings, media events, and in response to requests from external partners.

Community support centers, including 3 "Baby Café" mother-to-mother support drop-in centers and 2 new lactation resource/training centers opened.

State and local breastfeeding coalitions were provided technical assistance resulting in the formation of a State Breastfeeding Coalition Advisory Committee and 3 new local breastfeeding coalitions. The 2011 WIC Infant Feeding Practices survey was developed and a contract executed for distributing and processing the surveys. Two National Association of Government Communicators (NAGC) Blue Pencil & Gold Screen awards were won for the Every Ounce Counts campaign and educational activity kit. The August 2011 WIC breastfeeding initiation rate was 77.7%.

Activity 2: There were 75 Texas Ten-Step hospitals (11 new), 6 Baby-Friendly Hospitals (BFH), and 16 hospitals registered with Baby-Friendly USA to seek BFH status. Outreach included 80 health care professional training sessions, distribution of 33 unique materials designed for health care providers, and release of a new website ([texastenstep.org](http://texastenstep.org)). Work began to develop a smart phone application for the Healthcare Providers Guide to Breastfeeding. An 18-20 hour online hospital staff training module to address facility training needs was drafted with input from state and national breastfeeding experts. Two NAGC Blue Pencil & Gold Screen awards were won for Ten Step Star Achiever Program poster series and video.

Activity 3: Activities included continued implementation in the competitively awarded CDC Communities Putting Prevention to Work-State and Territory Initiative Special High Impact Initiative for Mother-Friendly Worksite Policy Initiative.

There were 378 new Mother-Friendly Worksites (MFW) designated, including 114 HHSC locations and 244 City of San Antonio locations. The City of San Antonio became the first Texas municipality (~11,000 employees) to adopt a MFW policy. A MFW policy was adopted covering the Texas Health and Human Service Enterprise (5 health agencies and approximately 56,000 employees).

Over 30 new MFW program development tools were developed. Technical assistance was provided to 25 public agencies and 36 trainings and webinars were held. Outreach to 40 state agencies, local health departments, and public hospitals led to 18 contracts executed to support MFW.

A needs assessment survey was conducted of over 10,000 employees at 25 worksites. Formative assessment was completed including interviews with 27 outreach partners and with 35 non-MFW and 40 MFW business leaders. Focus groups in 6 cities with 119 participants including breastfeeding working women, male partners of working mothers, and employers were completed. Formative assessment findings were reported to the CDC Division of Nutrition, Physical Activity, and Obesity Prevention staff.

A new website was launched ([Texasmotherfriendly.org](http://Texasmotherfriendly.org)). Work began to develop messaging and communication strategy for MFW Policy Initiative campaign. MFW proposed rules were published in the Texas Register for public comment.

Activity 4: Activities included 6 DSHS infant feeding workgroup meetings. A State Breastfeeding Coordinator was designated within DSHS to coordinate state breastfeeding efforts including activities integrated into DSHS Healthy Texas Babies initiative. Additionally, DSHS collaborated with Office of Attorney General and Texas Department of Agriculture to include breastfeeding activities in their agency initiatives.

Performance Assessment: Annual indicators seem to be improving and DSHS staff continue to build on earlier investments in support of breastfeeding.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop promotion and support of breastfeeding in the community.			X	X
2. Develop promotion and support for breastfeeding in health care systems.			X	X
3. Develop promotion and support for breastfeeding in the workplace.			X	X
4. Increase integration of breastfeeding promotion and support into DSHS programs.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: Staff coordinated and participated in coalition meetings and community partnerships. Multiple professional presentations were given. A new DSHS/WIC supported Baby Café drop-in center opened. The February 2012 WIC breastfeeding initiation rate was 81.6%.

Activity 2: There are 75 Texas Ten Step hospitals, 6 Baby-Friendly Hospitals (BFH), and 26 hospitals registering intent for BFH, an increase of 10 hospitals. Outreach included 96 health professional training sessions. An online training module was developed. An educational booklet was sent to all birthing hospitals.

Activity 3: Activities included 117 new MFWs designated; 8 professional presentations; 3 conference exhibits, 4 webinars held; MFW program rule revised; field tested messaging; development of communication strategy, print materials, and website began; billboards displayed in 15 markets; magazine print ad run; 6 online videos developed; 76 evaluation interviews completed; sustainability plan drafted; coalition funded to promote MFW; state agencies recruited for mini-grants.

Activity 4: Activities included 3 infant feeding workgroup meetings, MFW committees developed in the state HSRs, technical assistance for breastfeeding coalition development, and breastfeeding promotion integrated into multiple initiatives at DSHS.

***An attachment is included in this section. IVC\_NPM11\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Develop promotion and support of breastfeeding in the community.

Output Measure(s): Completed community support report including indicators related to breastfeeding rates; information, communication, referrals, and outreach activities; mother-to-mother support; professional support; and infrastructure building activities.

Monitoring: Review progress toward completion of report.

Activity 2: Develop promotion and support for breastfeeding in health care systems.

Output Measure(s): Completed health services report including indicators related to birth facility support and information, education, and communication for health services.

Monitoring: Review progress toward completion of report.

Activity 3: Develop promotion and support for breastfeeding in the workplace.

Output Measure(s): Completed workplace report including indicators related to increasing support for breastfeeding in the workplace through population based activities and infrastructure building activities.

Monitoring: Review progress toward completion of report.

Activity 4: Increase integration of breastfeeding promotion and support into DSHS programs.

Output Measure(s): Number and types of activities implemented within DSHS from the DSHS Infant Feeding Strategic Plan.

Monitoring: Document progress toward implementation of strategic plan.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	92	96	94	94	94
Annual Indicator	92.5	93.1	95.8	96.0	96.3
Numerator	379007	383596	391126	376976	369769
Denominator	409639	412099	408391	392752	384071
Data Source		Newborn Screening Database and Natality Data			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	96.5	96.5	96.5	96.5	96.5

**Notes - 2011**

Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence. In 2011, the denominator is based on a provisional birth file from CHS.

**Notes - 2010**

Update: 2010 births are final.

Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence.

**Notes - 2009**

Update: 2009 data is final.

**a. Last Year's Accomplishments**

Activity 1: The DSHS Texas Early Hearing Detection and Intervention (TEHDI) program monitored 251 facilities for adherence to the newborn hearing screening mandate finding 157 facilities compliant. The program certified 161 birthing facilities. The certification process provides birthing facilities with a rating based on standards. Facilities can be rated as: Distinguished (three years until the next review), Standard (one year until the next review), Provisional (6 months until the next review), or Preliminary (initial certification process). Of the birthing facilities certified in FY11, 101 (63%) were Distinguished, 34 (21%) were Standard, 18 (11%) were Provisional, and 8 (5%) were Preliminary.

Activity 2: Of the 376,088 infants born in facilities reporting to the TEHDI program, 373,368 received a hearing screen before hospital discharge. This represents 99% of infants born in facilities reporting to the TEHDI program and is projected to represent 96.3% of infants born in Texas during 2011. Of those screened, 363,895 (97%) passed the screening and 11,496 (3%) required follow-up upon discharge including 2,023 infants who missed the screening and 9,473 infants who did not pass the birth screen.

Activity 3: The TEHDI program completed a comprehensive training curriculum during FY11. The curriculum has eight modules for each of the major stakeholders within the early hearing detection and intervention process including TEHDI Overview, Prenatal, Universal Newborn Hearing Screening (UNHS), Outpatient Hearing Screening, Audiology, Ear, Nose and Throat (ENT), Medical Home, and Early Intervention.

Development of all modules was completed in March 2011. The curriculum development occurred as a component of an overarching marketing campaign. A TEHDI brand and logo was created to establish a recognizable, cohesive and unique image for the program. The program exhibited at six conferences during the first and second quarter of FY2011, including Texas Pediatric Society (300 attendees), Texas Academy of Audiology (150 attendees), Texas Health Steps Provider Expo (120 attendees), National Early Hearing Detection and Intervention (EHDI) (600 attendees), Texas Speech-Language-Hearing Association Convention (4,000 attendees), and Women, Infants and Children (WIC) Conference (600 attendees).

The program conducted stakeholder meetings, specifically 13 TEHDI overview trainings, one TEHDI conference presentation on use of teleconferences, two TEHDI curriculum trainings for audiologists, 14 TEHDI trainings for audiologists, and two trainings for additional users of the system.

TEHDI publications (see attached for samples; full array of publications available online in English and Spanish at <http://www.dshs.state.tx.us/tehdi/Audiology-Services-Home.aspx>) were revised to reflect the new branding and up-to-date information regarding the program. The program created additional new TEHDI publications to coincide with the training curriculum and outreach efforts to a broader spectrum of stakeholders. The newly designed brochures went into publication during the first quarter of FY11. A total of 460,313 materials were distributed during FY11.

Activity 4: The TEHDI contractor performed 19 onsite TEHDI trainings for hospital staff and the TEHDI staff presented eight continuing education (CE) accredited Universal Newborn Hearing Screening (UNHS) curriculum modules to hospital staff. A total of 25 CE accredited presentations were conducted for the medical home population.

The TEHDI program has a free online Newborn Hearing Screening module, housed on the THSteps website. The course was completed by 349 individuals (46 doctors, 233 nurses, 14 social service providers, 11 speech, language and hearing providers, 4 surgery service providers, 3 physician assistants or nurse practitioners, and 38 others).

The TEHDI program and contractor continue to provide outreach to the medical home in the online module Provider Access. The outreach campaign includes monthly postcard notifications and office visits from DARS staff called Resource Specialists. Provider Access has a total of 479 users with 225 new users.

Performance Assessment: The state has surpassed the HP 2020 target of 90.2% but will continue to provide training and outreach to increase the percentage of newborns screened.

***An attachment is included in this section. IVC\_NPM12\_Last Year's Accomplishments***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria.				X
2. Evaluation of the TEHDI program utilizing system data to manage the program.				X
3. Collaborate with multiple stakeholders to develop and disseminate educational materials for providers and parents.			X	
4. Provide training, outreach, and technical assistance to hospitals and medical home providers.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: The TEHDI program monitored 256 facilities with 177 facilities in compliance with the newborn screening mandate and 79 facilities noncompliant and requiring follow-up. The program certified 69 birthing facilities by midyear FY12. Legislation passed during the 82nd legislative session has increased the number of facilities requiring certification by removing exemptions and expanding the definition of a birthing facility. The program is currently reviewing proposed changes to the compliance and certification process.

Activity 2: 186,825 infants born in facilities reporting to the TEHDI Program needed a newborn hearing screening and 185,234 (99%) of these were screened before discharge. Of those screened, 180,904 (98%) passed and 5,307 (3%) required follow-up, including 977 (1%) who missed the screening and 4,330 (2%) who did not pass the birth screen.

Activity 3: Education included 2 conference exhibitions, a train-the-trainer session for nursing instructors, an online continuing education training module, and distribution of 329,461 materials.

Activity 4: Birthing facility staff training included 19 web-based trainings, 9 onsite presentations, and an online module. There were 86 new providers using the hearing management information system. Technical assistance was provided to one user.

**An attachment is included in this section. IVC\_NPM12\_Current Activities**

**c. Plan for the Coming Year**

Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria.

Output Measure(s): Number of compliant and noncompliant programs that report newborn hearing data to DSHS.

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

Activity 2: Evaluation of the TEHDI program utilizing system data to manage the program.

Output Measure(s): Number and percent of infants screened before discharge from a birthing facility, number and percent of infants who do not pass the birth screen, number and percent of infants who did not receive a birth screen and number and percent of infants requiring follow-up.

Monitoring: Review of system data utilizing quarterly reports generated by the hearing management information system.

Activity 3: Collaborate with multiple stakeholders to develop and disseminate educational materials for providers and parents.

Output Measure(s): Number and type of stakeholders involved in activities, type and number of materials developed and disseminated, number of stakeholder meetings held.

Monitoring: Documentation of meetings held and number of educational materials distributed; Review THSteps CE module completion records.

Activity 4: Provide training, outreach, and technical assistance to birthing facilities, audiologists, early intervention specialists, and medical home providers.

Output Measure(s): Type and number of trainings delivered, number of new medical home providers utilizing the hearing management information system and technical assistance provided.

Monitoring: Review of the quarterly reports generated by the electronic hearing management information system and other TEHDI databases developed.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	19.9	20	20	19.5	17
Annual Indicator	21.4	17.9	16.3	16.3	14.3

Numerator	1434980	1216968	1133117	1152738	1031829
Denominator	6720386	6783441	6966193	7072725	7203681
Data Source		US Census Bureau, Current Population Survey			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	14	14	13.7	13.7	13.7

**Notes - 2011**

2011 data is a projection based on previously reported 2006-2010 reported outcomes.

**Notes - 2010**

Update: 2010 data is now based on the Census data.

Source: [http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

**Notes - 2009**

Data presented in the columns from 2007 through 2009 are correct and final. This indicator has been adjusted for final data. Numerator and denominator data are provided by the US Census Bureau, Current Population Survey, Annual Social and Economic Supplement([http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)).

**a. Last Year's Accomplishments**

Activity 1: According to estimates provided through the US Census Bureau's 2009 American Community Survey, there were currently approximately 7,072,725 children under the age of 18 residing in Texas. Of these children, approximately 1,152,738 (16.3%) do not have health insurance coverage.

Activity 2: Excluding those served through CSHCN SP contractors, there were 31,533 individuals under the age of 21 served by Title V-funded contractors throughout the state. Of those, 2,461 were enrolled in the prenatal program, 14,820 in the child health program, and 14,252 in the dental program.

Activity 3: DSHS regional staff provided information and referrals for families of children accessing services through DSHS clinics and worked with community coalitions, local Community Resource Coordination Groups (CRCGs) and schools to improve children's access to insurance through participation in health fairs and other activities. DSHS staff assisted families whose children were uninsured in over 3,000 referrals to CHIP or children's Medicaid services.

Performance Assessment: Although there are improvements in the number of children with public and/or private insurance, Texas Title V program staff and contractors continue to link families with Medicaid and CHIP at every opportunity. Future changes in the public/private health care environment will require flexibility in Title V program planning and operations.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and report the percentage of children without health insurance.				X
2. Screen all children at Title V-funded clinics for potential CHIP (including the new CHIP perinatal benefit) and Medicaid eligibility and make referrals to appropriate programs.			X	X
3. Identify and develop partnerships with internal and external stakeholders to increase children's access to insurance.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: Estimates are developed from various sources for calendar years. There are no updates for this activity until the end of FY12.

Activity 2: Excluding those served through CSHCN SP contractors, there were 18,427 individuals under the age of 21 served by Title V-funded contractors throughout the state. Of those, 1,221 were enrolled in the prenatal program, 10,272 in the child health program, and 6,934 in the dental program.

Activity 3: DSHS regional staff provided information and referrals for families of children accessing services through DSHS clinics and worked with community coalitions, local Community Resource Coordination Groups (CRCGs) and schools to improve children's access to insurance through participation in health fairs and other activities. DSHS staff assisted families by making 2,200 referrals to CHIP/Medicaid and 420 referrals to DSHS Title V Child Health/Dental Contractors.

***An attachment is included in this section. IVC\_NPM13\_Current Activities***

**c. Plan for the Coming Year**

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

Output Measure(s): Percent of children without health insurance.

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

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

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

Monitoring: Periodic quality assurance reviews of contractors.

Activity 3: Identify and develop partnerships with internal and external stakeholders to increase children's access to insurance.

Output Measure(s): Number and types of partnerships and trainings, activities, and resources developed/distributed; summary report on collaborative efforts undertaken.

Monitoring: Track the number and type of partnerships, trainings, and activities; documentation of materials created and/or distributed; review of Health Service Region reports.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	22	21	23	29	31
Annual Indicator	24.1	31.5	31.4	34.7	35.7
Numerator	164231	146631	140676	171101	177273
Denominator	680571	465319	448039	492775	496167
Data Source		WIC Program Data	WIC Program Data	WIC Program Data	WIC Program Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	33	32	31	30	30

**Notes - 2011**

2011 data is projection based on 2006-2010 data

**Notes - 2010**

Data for 2005, 2006 and 2007 are for children ages one to five years of age. This was due to an error in the code used to create the tables. Data for 2008, 2009, and 2010 are correct. The targets for 2008, 2009, and 2010 are not reflective of this error.

Denominator data are all children ages two to five years of age. These data are reported through certification data provided by the WIC program. Numerator data are all children with a BMI at or above the 85th percentile as noted in the Health and Nutrition Risk Tables provided by the WIC program.

**Notes - 2009**

Data for 2005, 2006 and 2007 are for children ages one to five years of age. This was due to an error in the code used to create the tables. Data for 2008, 2009, and 2010 are correct. The targets for 2008, 2009, and 2010 are not reflective of this error.

This indicator has been adjusted for final data. Denominator data are all children ages two to five years of age. These data are reported through certification data provided by the WIC program. Numerator data are all children with a BMI at or above the 85th percentile as noted in the Health and Nutrition Risk Tables provided by the WIC program.

**a. Last Year's Accomplishments**

Activity 1: Of the 504,203 WIC enrolled women, 446,930 (88.6%) received nutrition education and 1,483,393 (87.5%) of the 1,695,564 total WIC population (women and children) enrolled received nutrition education.

Thirty-eight local WIC agencies were allocated \$445,000 as Obesity Prevention Mini Grants (OPMG) to plan, implement, and evaluate their projects. Funds were used for prevention initiatives such as healthy cooking demonstrations, establishing community gardens, promoting physical activity by establishing walking groups, health fairs and carnivals, and conducting supermarket tours.

Sixty-four WIC agencies received a total of \$1,895,240 to fund salaries of contracted Registered Dietitians (RDs) or to defray the cost of staff dietitians.

Activity 2: Texas Food and Nutrition Questionnaire (TEXFAN) staff completed the remaining 3 research question reports for pre-rollout results and prepared summaries for all 10 questions. TEXFAN completed collection of almost 7,000 post-rollout surveys, cleaned the post-rollout data, and prepared reports for Texas WIC.

The WIC Infant Feeding Practices Survey was developed and reviewed by local WIC Directors, local WIC Breastfeeding Coordinators, and other public health partners including staff from the Centers for Disease Control and Prevention. Survey revisions included elimination of some questions and addition of questions to assess status of priority areas identified in the US Surgeon General's Call to Action to Support Breastfeeding. The sampling methodology was determined and the application for review and exemption from the DSHS Institutional Review Board was drafted with the survey to be conducted in FY12.

Activity 3: The contract with SUMA/Orchard Social Marketing, Inc. ended October 2010. No work with regard to food redemption or participant retention was conducted in FY11.

Performance Assessment: The number of children with a BMI at or above the 85th percentile who receive WIC services has increased slightly from 2009 despite efforts at the state and local level to address childhood obesity. DSHS continues to implement activities locally and statewide which include local obesity prevention activities via mini-grants, breastfeeding retention efforts, and increasing the number of Registered Dietitians on-site at WIC locations. Exploring further opportunities for education and prevention activities and a continued and expanded focus on childhood nutrition, physical activity, and breastfeeding throughout DSHS may contribute to future reductions in childhood obesity.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.			X	
2. Study food consumption patterns in WIC families.				X
3. Identify factors that affect the redemption rate for WIC participants and the length of time participants remain on the WIC program.				X
4.				

5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: Of the 368,696 WIC enrolled women, 320,612 (87.0%) received nutrition education and 1,076,448 (80.1%) of the 1,343,882 total WIC population (women and children) enrolled received nutrition education.

Thirty-seven local WIC agencies involved in the Obesity Prevention Mini Grant (OPMG) held activities such as healthy cooking demos and creating community gardens. Over 66% of projects targeted WIC families and over 28% also included WIC staff.

Activity 2: Administration of the 2011 WIC Infant Feeding Practices Survey was completed. 12,000 surveys were distributed to over 450 WIC clinics to mothers of infants aged 3 mo-1 yr who received WIC services during pregnancy. Data entry began for open response questions and a data code book was developed.

Fruit and vegetable purchases of WIC participants indicate the top purchased produce as bananas, tomatoes, grapes and avocados. Trends in milk type (2%, 1%, Fat-free) indicate a preference for 2% (~93%) over other low-fat milks.

Activity 3: Local WIC agencies were asked to develop outreach plans to ensure that potentially eligible persons are aware of WIC and know where to seek services. Outreach activities include distribution of information twice a year about WIC to agencies and individuals that serve or work with potentially eligible persons, including grassroots organizations, hospitals, community health centers, physicians, and pharmacies. Potential eligible percentage for Texas WIC is 68.9% (as of November 2011).

***An attachment is included in this section. IVC\_NPM14\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.

Output Measure(s): Number of WIC participants receiving nutrition education at time of benefit issuance; type and number of activities included; funding of WIC obesity projects; funding registered dietitians at clinics to engage children at risk for obesity; number of new mothers who choose to breastfeed.

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

Activity 2: Study food purchase patterns in WIC families.

Output Measure(s): Number of surveys and studies conducted; reports and presentations of findings; track purchases of low-fat milk (1% or less) and all fresh/frozen fruits & vegetables.

Monitoring: Track quarterly progress.

Activity 3: Conduct outreach to inform potentially eligible persons about the benefits and availability of the WIC Program.

Output Measure(s): Type and number of activities included; percentage of potentially eligible participants serve by the WIC program.

Monitoring: Track progress on activities. Track potential eligible participants biannually.

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

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	7.2	7.5	8	8	6.9
Annual Indicator	8.3	6.0	8.3	7.0	6.3
Numerator	32882	24517	35188	26925	23887
Denominator	396167	405242	425467	385746	376688
Data Source		PRAMS and Natality Data			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	6	6	5.8	5.8	5.6

**Notes - 2011**

PRAMS data for Texas are only available through 2010. The estimate for 2011 is a linear projection based on PRAMS data from 2006 through 2010. Denominator data are all live births. Birth estimates for 2011 are based on a provisional natality file.

**Notes - 2010**

Update: The PRAMS and birth data for 2010 are final.

**Notes - 2009**

Update: PRAMS and natality data are final.

**a. Last Year's Accomplishments**

Activity 1: The Tobacco Prevention & Control Program received funding from Title V to develop and place media targeting pregnant women ages 18-40 or women that have infant children by using a visual of a baby bottle that is consumed like a cigarette. The voiceover reminds the viewer of the hazards of smoking while pregnant and around small children, while leading them to cessation resources to help them quit. This new message ran in summer 2011 and will be used again for an upcoming New Year's Day cessation media campaign in FY12.

For pregnant women, Alere Wellbeing, Inc., has a targeted counseling protocol that includes the

risk to the baby during and immediately following pregnancy. In addition, there are specific protocols that can allow pregnant women to receive nicotine replacement therapy as part of the cessation treatment plan.

An estimated 26,000 individuals contacted the Quitline with more than 12,000 receiving counseling services. Statewide, approximately 55% of all callers to the Quitline are women and 68% are between the ages of 18 and 50. While a small percentage of the women who call are pregnant, a significant number are of childbearing age.

DSHS regional staff participated in community activities related to tobacco cessation for pregnant women through participation in Great American Smoke Out activities, health fairs, and distribution of prevention and cessation materials.

Activity 2: According to 2010 PRAMS data, approximately 6.0% of teens of all races between the ages of 13-19 smoked in the last three months of pregnancy. For women of all races over the age of 20, approximately 7.1% smoked in the last three months of pregnancy. When examined by race, whites have the highest rates in the teen age group (13-19), with approximately 13.7% smoking in the third trimester. Approximately 7.4% of black women and 13.8% of white women over the age of 20 smoked in the last three months of pregnancy. While approximately 11.4% of women aged 18-44 smoked in the 3 months after pregnancy, rates were higher for whites (19.7%) than blacks (17.4%) and Hispanics (5.6%).

Activity 3: A DSHS intern assisted staff in the development of a smoking cessation training for community health workers and promotores with a draft sent to internal DSHS stakeholders. Feedback was received and incorporated with the material to begin use in FY12.

Performance Assessment: Although data indicate overall smoking rates are decreasing, white teens and women over 20 still are over 13% during the last trimester. Continued efforts to provide education and treatment is required.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement tobacco cessation social marketing campaign targeting pregnant women and expectant fathers.			X	
2. Monitor smoking rates in the last three months of pregnancy among adults and teens by race and ethnicity.				X
3. Develop and implement training for promotores/community health workers to provide smoking cessation interventions during pregnancy.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: A media campaign is in the preliminary stages with discussions between the DSHS Tobacco Prevention and Control Program and their contractor, EnviroMedia Social Marketing. Early campaign ideas include developing a new radio spot as well as posters and other non-traditional media elements that will run during the fourth quarter of FY 2012. These messages will compliment the television message targeting women that was created in FY 2011. It is expected

that the scope of work will be completed in April 2012 with contract amendments following shortly.

Activity 2: According to PRAMS data, the estimated percent of women who reported smoking during the last three months of pregnancy was 7.0% (95% CI: 5.5-8.4). Among teens between the ages of 13-19, approximately 6.0% smoked in the last three months of pregnancy. Broken down by race, the rates are as follows for ages 13-19: approximately 2.2% of black women, 4.2% of Hispanic women and 13.7% of white women smoke.

Activity 3: A smoking cessation training for community health workers is in development by one of the DSHS-certified community health worker programs.

***An attachment is included in this section. IVC\_NPM15\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Support statewide tobacco prevention and cessation efforts that target men and women of childbearing age and their families.

Output Measure(s): Reports detailing media campaign impact; number of calls to Quitline resulting from activities; other activities that promote tobacco prevention and cessation.

Monitoring: Track activity progress and development of reports; review quarterly Health Service Region reports.

Activity 2: Monitor smoking rates in the last three months of pregnancy among adults and teens by race and ethnicity.

Output Measure(s): Written review of data, data review communicated to external stakeholders including March of Dimes, Healthy Start, WIC and Title V fee-for-service and population-based providers; information on website, including referral resources for providers and clients.

Monitoring: Review birth record, PRAMS, and Texas BRFSS data as available.

Activity 3: Develop, implement, promote, and evaluate training for promotores/community health workers to provide smoking cessation interventions during pregnancy.

Output Measure(s): Training module developed and disseminated to approved organizations providing DSHS certified continuing education for promotores/community health workers; number of DSHS approved training programs adding the module to their approved curriculum; number of continuing education programs using the module held by DSHS approved training programs and number of participants trained; evaluation completed and documented.

Monitoring: Track development of module at regular work group meetings; track implementation of module through regular contact with the training programs and reports available on request.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	7.6	6	5.5	5.2	7.5
Annual Indicator	6.4	7.2	8.7	7.5	7.8
Numerator	118	134	163	142	150
Denominator	1840936	1866100	1882929	1883124	1927596
Data Source		Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	7.4	7.3	7.2	7.1	7.1

**Notes - 2011**

Mortality data reported for 2011 is estimated. Estimates are linear projections based on data from 2006 through 2010.

Denominator data is a population estimate by the Office of the State Demographer.

**Notes - 2010**

June 2012: Mortality data for 2010 is now final.

Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 2003 through 2008.

Denominator is 2010 Census data.

**Notes - 2009**

June 2012: Mortality data for 2009 has been finalized.

Denominator data provided by the Office of the State Demographer.

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

Activity 1: Mental Health America Texas (MHAT) developed and posted the "Texas Statutes Related to Suicide" document, an announcement about the 2011 Texas Suicide Prevention Symposium, and the January 2011 Texas Suicide Prevention e-Newsletter on [www.texassuicideprevention.org](http://www.texassuicideprevention.org), which was sent to 2,000 subscribers. Over 225,000 printed materials were distributed.

MHAT developed an Android Application for suicide prevention with direction to locate the app on the website [www.texassuicideprevention.org](http://www.texassuicideprevention.org). MHAT conducted Awareness Training at the Annual Fall Substance Abuse Prevention Providers meeting in Austin.

Activity 2: Over 70 Question, Persuade, and Refer (QPR) and ASK (Ask about suicide, Seek more information, Know how and where to refer) trainings were conducted. More than 2,500 individuals were trained as gatekeepers and 88 as ASK instructors. Twenty-seven exhibits on suicide prevention for youth were conducted. Over 1,600 individuals were trained through the At-Risk Online Training for high school teachers.

Activity 3: The Suicide Prevention Council (SPC) met for their yearly meeting at the annual suicide prevention symposium. Seven new local suicide prevention coalitions were added in Abilene, El Paso, Milam County, Austin, East Texas, Lubbock, and central Texas. The SPC provided consultation to coalitions, school districts and organizations in the cities of Alvin, Austin, Beaumont, Brownsville, Big Bend, Crandall, Dallas, Dripping Springs, Houston, Killeen, Lake Travis, Leander, Plainview, Rockdale, San Angelo, San Antonio, Springtown, Sulphur Springs, and Waco as well as Bastrop, Brazoria, Travis, and Williamson counties. Other consultation was provided to ESCs, CFRTs throughout the state, and organizations such as National Suicide Prevention Lifeline, Texans Care for Children, and the Youth Suicide Prevention project in Oregon.

House Bill 1386 was passed during the 82nd Legislative session, which requires school districts to have a suicide prevention plan as part of their campus improvement plan. This legislation required DSHS to make a list of best practice and evidence-based suicide prevention programs available to schools and districts through the Texas Education Agency. Implementation of this legislation will begin in FY12.

DSHS regional staff participated in local or regional suicide prevention coalitions (SPC) including the Texas Panhandle SPC, South Plains Suicide Coalition (HSR 1), I AM HERE coalition (HSR 2/3), Save a Life Today (SALT) Coalition (HSR 4/5N), Austin/Travis County SPC, Bastrop County SPC, and Highland Lakes SPC (HSR 7). Additional activities included working with CFRTs and school districts/School Health Advisory Councils regarding information and resources related to bullying. Several DSHS regional staff completed ASK suicide prevention training and shared information about the training with schools and other community partners. DSHS staff shared relevant data or participated in activities or planning related to suicide prevention at more than 200 meetings.

Activity 4: The Johnson County CFRT has a long successful relationship with seven school districts that provide training to students, faculty and parents on a variety of safety issues. These presentations are done in elementary schools, middle school and high schools. Due to several youth suicides in the county, they developed and incorporated training that addresses bullying, cyber-bullying and suicide prevention. They conducted 22 presentations reaching approximately 3,000 students. CFRT members in Nacogdoches, Anderson, Polk, Panola, Rusk and Harrison Counties in East Texas have been instrumental in the formation, promotion and activities of the Save a Life Today (SALT) Suicide Prevention Coalition. Training workshops for CFRT members were conducted in each of the DSHS Health Service Regions. In each of the training sites (Amarillo, Arlington, McAllen, Nacogdoches, Odessa, Round Rock, San Antonio, and The Woodlands), 316 attendees received the suicide prevention gatekeeper training, Ask About

Suicide to Save a Life. As a result of the presentation in McAllen, a new Suicide Prevention Council was formed in the Lower Rio Grande Valley, and there are plans to deliver the training to all Health and Human Services staff in the area.

Performance Assessment: Rates have continued to remain fairly stable over time among this population. Access to evidence-based resources and training continue to help prevent suicide in this age group.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Broaden the public's awareness of youth suicide, its risk factors, and prevention.			X	
2. Provide training to individuals, communities, and schools to identify and refer youth at higher risk of suicide and suicide attempts.			X	X
3. Provide support to internal and external stakeholders addressing suicide prevention.				X
4. Report on suicide deaths of 15-17 year olds and CFRT activities to promote suicide prevention.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: Over 367,000 printed materials have been distributed. The Best Practice list for suicide prevention (SP) for schools was added to the website and 7,375 downloads have been made for the SP smart phone application as of February 29, 2012. 40 exhibits on SP have been held.

Activity 2: More than 4,000 individuals were trained through 130 QPR & ASK gatekeeper trainings. Nearly 100 instructors have become ASK trainers and DSHS approved ASK for community health workers. Fifteen colleges have partnered for the online training for student and faculty SP. Nearly 600 individuals received information on SP through presentations, workshops and trainings through the Texas School Health Network project.

Activity 3: Eight SP coalitions and 6 community groups received consultation on SP and postvention. To date, 3,763 high school educators have enrolled in the Kognito online training. DSHS regional staff participated in local or regional SP coalitions, provided CFRTs and school districts information and resources on bullying, completed ASK training and shared information with schools and community partners. DSHS staff shared relevant data or participated in activities or planning on SP at more than 130 meetings.

Activity 4: Members of 3 East Texas CFRTs helped create a new coalition that covers 12 counties. They participated in the SP walk sponsored by a coalition this quarter. Nearly 125 individuals participated in the walk and raised \$2,500 for SP.

***An attachment is included in this section. IVC\_NPM16\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Broaden the public's awareness of youth suicide, its risk factors, and prevention.

Output Measure(s): Maintain Website for suicide prevention information and resources; number of public awareness activities.

Monitoring: Document updates for the website regarding suicide information and prevention; document public awareness activities.

Activity 2: Provide training to individuals, communities, and schools to identify and refer youth at higher risk of suicide and suicide attempts.

Output Measure(s): Number of individuals and communities trained in suicide prevention best practices (i.e. QPR (Question, Persuade, Refer), ASK (Ask about suicide, Seek more information, Know how and where to refer), ASIST (Applied Suicide Intervention and Skills Training), and middle and high school At-Risk (At-Risk is an interactive, web-based training simulation to teach school staff to effectively identify, approach and refer students At-Risk of suicide or suicide attempts)).

Monitoring: Documentation of suicide prevention best practice trainings completed.

Activity 3: Provide support to internal and external stakeholders addressing suicide prevention.

Output Measure(s): Participate in the Texas Suicide Prevention Council; Obtain information about the Suicide Prevention Coalitions established statewide; number of regional activities.

Monitoring: Review meeting notes from the Texas Suicide Prevention Council; document suicide prevention activities implemented by the Council; track the contact information of the Suicide Prevention Coalitions; document local suicide prevention activities; review quarterly Health Service Region staff reports.

Activity 4: Report on suicide deaths of 15-17 year olds and CFRT activities to promote suicide prevention.

Output Measure(s): Public awareness/educational materials developed; suicide deaths of youth 17 and younger reported in the State Child Fatality Review Team Committee annual report; number of trainings on developing suicide prevention initiatives presented to CFRTs; and number of local initiatives developed by or participated in by CFRTs.

Monitoring: Track materials that are developed; provide updates of youth 17-and younger suicide deaths and local CFRT training and suicide prevention activities at quarterly State Committee meetings.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	55	52	52	52	50
Annual Indicator	48.2	50.2	50.1	49.8	48.2
Numerator	2849	2946	2967	2810	2631

Denominator	5913	5865	5920	5641	5455
Data Source		Annual Hospital Survey and Natality Data			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	50	51	51.5	52	52

**Notes - 2011**

Using the Annual Hospital Survey from the Texas Center for Health Statistics, high risk hospitals are identified. A variable is created in the natality file to differentiate high risk hospitals from all others. All natality data reported for 2011 are based on provisional (non-final) data.

**Notes - 2010**

June 2012: Natality data for 2010 has been finalized.

Using the Annual Hospital Survey from the Texas Center for Health Statistics, high risk hospitals are identified. A variable is created in the natality file to differentiate high risk hospitals from all others.

**Notes - 2009**

Update: Natality data for 2009 has been finalized.

Using the Annual Hospital Survey from the Texas Center for Health Statistics, high risk hospitals are identified. A variable is created in the natality file to differentiate high risk hospitals from all others.

**a. Last Year's Accomplishments**

Activity 1: Staff reviewed literature and work from other states to determine existing best practices. After meeting with DSHS Regulatory Services in FY10, it was determined that pursuit of other partnerships will be necessary to move forward in exploring standard definitions for level of care.

Networking occurred with Healthy Texas Babies Expert Panel (HTB-EP) members interested in developing statewide definitions and standards for levels of care and testing those standards at a local/regional level. A HTB-EP provider workgroup was formed to develop an intervention action plan and make recommendations for actions needed to develop maternal transfer algorithms so that the deliveries of Very Low Birth Weight & Extremely Low Birth Weight infants occur at facilities for high-risk deliveries and neonates.

Work began in coordination with HHSC to develop surveys for Texas birthing facilities to assess

consistency with self-designated levels of care and facility capacity for perinatal and neonatal care. HB 2636 charged HHSC to develop a council to study and make recommendations regarding neonatal intensive care unit (NICU) operating standards and reimbursement through the Medicaid program for services provided to an infant admitted to a NICU. The council will develop standards for operating a neonatal intensive care unit in Texas, develop an accreditation process for a NICU to receive reimbursement for services provided through the Medicaid program, and study and make recommendations regarding best practices and protocols to lower admissions to a NICU.

Activity 2: A map of level III obstetric hospitals was created. The process entailed development of a list of hospitals that self-designated in response to the American Hospital Association (AHA) annual survey of hospitals.

Activity 3: For 2011, the most recent year that final birth data is available is 2008, data indicate that 48.1% (n=2067) of singleton very low birth weight (VLBW) babies born in Texas to Texas residents were born in a level III\* hospital. For multiple VLBW births, 56.0% (n=879) of those babies were born in a level III\* hospital. In total, 50.2% (n=2946) of all VLBW births in Texas to Texas residents occurred at a level III\* hospital.

Using the most recent final birth data from 2008, the mothers of 271 VLBW infants born in Texas (4.6% of VLBW births) were transferred for maternal medical or fetal indications, and 705 infants (11.9%) were transferred within 24 hours of delivery.

\*Level is based on AHA self-designated obstetric level.

Performance Assessment: With continued decline in performance indicators for this measure, DSHS will maintain and explore new efforts to address the problem with stakeholders through the Healthy Texas Babies initiative.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop partnerships with internal and external stakeholders (e.g. Texas DSHS Division for Regulatory Services, Texas Hospital Association) to explore standardization of neonatal level of care designations.				X
2. Define and map location of level III neonatal hospitals in Texas using hospital obstetric level self-designation status data, presence of a neonatal intensive care unit (NICU), number of NICU beds, and other criteria from the American Hospital Association.				X
3. Monitor rate of very low birth weight (VLBW) infants delivered at facilities for high-risk deliveries and neonates through the analysis of birth record data.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: A DSHS Healthy Texas Babies (HTB) Workgroup Maternal Transport Committee was formed to begin operationalizing Expert Panel recommendations for maternal transfer algorithms

so that Very Low Birth Weight infants are delivered at facilities for high-risk deliveries and neonates. Staff reviewed and discussed existing state models. HTB-EP members were recruited for work group meetings. Goals were established to develop algorithms for common maternal/fetal conditions necessitating transfer including preterm labor, placental problems, and hypertension, as well as to develop a model for establishing agreements between community and anchor facilities. Members for the HHSC Neonatal Intensive Care Unit (NICU) Council were selected.

Activity 2: Questionnaires to assess Texas birthing facilities consistency with self-designated levels of care and facility capacity for perinatal and neonatal care were developed in coordination with HHSC. The electronic questionnaires were sent to each Texas birthing facility. The response rate was 62% by midyear FY12. Follow-up communication with non-responsive facilities is planned for Q3 to ensure full participation.

Activity 3: In 2009, the most recent year that final birth data is available, 47.5% (n=2997) of very low birth weight (VLBW) babies born in Texas to Texas residents were born in a level III\* hospital.

\*Level is based on AHA self-designated obstetric level.

**An attachment is included in this section. IVC\_NPM17\_Current Activities**

**c. Plan for the Coming Year**

Activity 1: Develop partnerships with internal and external stakeholders to build capacity for standardization of neonatal level of care designations.

Output Measure(s): Number and type of contacts with internal and external partners regarding the standardization.

Monitoring: Document communication.

Activity 2: Monitor rate of very low birth weight (VLBW) infants delivered at facilities for high-risk deliveries and neonates through the analysis of birth record data.

Output Measure(s): Number and proportion of VLBW infants delivered at level III hospitals; number and percent of high risk women transferred prior to delivery; number and percent of infants transferred within 24 hours after birth.

Monitoring: Document the rate of VLBW infants delivered at facilities for high risk deliveries and neonates using data from the annual AHA survey and birth record.

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

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	85	73	74	66	58
Annual Indicator	62.6	57.9	54.9	56.9	59.4
Numerator	249155	234829	220473	219333	223994
Denominator	398319	405242	401599	385746	377124
Data Source		Nativity Data	Nativity Data	Nativity Data	Nativity Data
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	64	65	65	65	65

**Notes - 2011**

2011 data is based on a provisional natality file from the Texas Center for Health Statistics.

**Notes - 2010**

Update: 2010 data is final.

**Notes - 2009**

June 2012: 2009 Data is finalized.

**a. Last Year's Accomplishments**

Activity 1: DSHS spearheaded the Healthy Texas Babies (HTB) initiative, a statewide effort to reduce infant mortality. The effort is led by DSHS, HHSC and the Texas Chapter of the March of Dimes. DSHS has also convened an Expert Panel comprising stakeholders from all regions and many sectors within maternal and child health in Texas. The initiative aims to reduce infant mortality through improved service and policy infrastructure in the state. Interventions implemented in FY2011 included a training for 300 community health workers (CHW) and promotores on effective grassroots strategies to reduce infant mortality, a communications campaign through the WIC program targeting the issue of elective preterm birth, and development of a survey to determine locations of and levels of care of the Neonatal Intensive Care Units (NICUs) in the state in order to improve access to appropriate obstetric and neonatal services.

14,949 women accessed prenatal care through Title V contractors. DSHS regional staff presented information on prenatal care to migrant Head Start teen mothers and provided referrals for pregnant women to CHIP Perinatal (over 500 women), Medicaid for pregnant women (over 800 women), and Women's Health Program (over 1,000 women).

DSHS regional staff partnered with community coalitions, FQHCs, and other providers to promote access to prenatal care. A Community Prematurity Summit was held in HSR 4/5N with key African American health leaders to build awareness of the high rate of pre-term birth and prepare to engage in a prematurity campaign. DSHS regional clinic staff provided referrals for pregnant women to CHIP Perinatal (over 1,000 women), Medicaid for pregnancy women (over 1,800 women), and Women's Health Program (over 2,000 women).

Activity 2: According to the 2010 birth certificate data for Texas, there were 385,746 births in Texas and 60.5% of women began prenatal care (PNC) in the first trimester. 63% of women received at least adequate PNC based on the Adequacy of Prenatal Care Index.

According to 2010 PRAMS, 74.6% of women reported that they began PNC in the first trimester (95% CI: 72.0-77.3). The estimated percent of women who reported receiving prenatal care as early as they wanted was 78.7% (95% CI: 76.2-81.3).

Activity 3: DSHS became more engaged in preconception and inter-conception care through the ongoing HTB initiative. DSHS became lead outreach partner of Text4baby in Texas in June 2011. This partnership allows DSHS to promote health messages about inter-conception care to

mothers of infants and links to resources on perinatal depression, medical home and birth spacing. Development of the DSHS HTB website was also initiated in June 2011. The website features portals of entry designed for women before, during and after pregnancy as well as their partners with pertinent information and links to resources such as fatherhood, life planning and health insurance access tools.

The HTB Expert Panel recommended insurer-facilitated direct-entry into inter-conception care for women with a history of preterm birth. The Expert Panel met in July 2011 and reviewed the recommendations and will continue to work on the recommended deliverables for the duration of the initiative. Messages about pre and inter-conception care were included in the HTB CHW trainings conducted around the state throughout the month of August 2011. DSHS continues to work closely with Healthy Start, providing support and advisement to their ongoing Perinatal Depression Study utilizing the Edinburgh Depression Screening Tool.

DSHS staff participated in 4 Medicaid Peer-2-Peer meetings. DSHS staff attended the Texas Office for the Prevention of Developmental Disabilities strategic planning meeting and advised the group to include preconception and inter-conception care in the plan. DSHS regional staff provided TA for the Nurse Family Partnership site in Amarillo.

Performance Assessment: The percent of women receiving prenatal care in the first trimester increased between 2010 and 2011. Title V continues to be a safety net for prenatal care along with Medicaid and the CHIP Perinatal program. Regional staff works to ensure that women eligible for these services are enrolled.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase infrastructure for improving access to prenatal care.				X
2. Monitor percent of infants born to women who received early and adequate prenatal care through the analysis of previously collected surveillance data.				X
3. Increase DSHS engagement in preconception and interconception health.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: The Healthy Texas Babies (HTB) initiative continued to place emphasis on early prenatal care through the launch of the HTB website. The website is designed for multiple users including mothers and fathers-to-be, their friends, family and employers and women's health providers and is available in English and Spanish. The importance of early prenatal care for mothers with a history of preterm birth was highlighted by the DSHS Grand Rounds, which described HTB and featured a case study of perinatal levels of care by an eminent neonatologist.

Activity 2: DSHS regional staff partnered with community coalitions, FQHCs, and other providers to provide information and promote access to prenatal care. DSHS regional clinic staff provided referrals for pregnant women to CHIP Perinatal and Medicaid for pregnant women (over 1,100 women), Women's Health Program (over 900 women), and Title V Prenatal contractors (over 160 women).

Activity 3: Efforts included development of an inter-agency committee including members of DSHS, HHSC, the HTB Expert Panel and the March of Dimes to create a life planning tool for young people to use to set life goals and plan their reproductive years. Four HTB coalitions are doing pre- and inter-conception projects using evidence-based models from other states.

**An attachment is included in this section. IVC\_NPM18\_Current Activities**

**c. Plan for the Coming Year**

Activity 1: Increase infrastructure for improving access to prenatal care.

Output Measure(s): Number and type of strategies to increase infrastructure for improving access to prenatal care, including regional activities; number of women receiving prenatal care through Title V contractors.

Monitoring: Document strategies.

Activity 2: Monitor percent of infants born to women who received early and adequate prenatal care through the analysis of previously collected surveillance data.

Output Measure(s): Percent of infants born to women who received early and adequate prenatal care.

Monitoring: Review birth record and PRAMS data.

Activity 3: Increase DSHS engagement in preconception and interconception health.

Output Measure(s): Number of partners and initiatives DSHS participates in pertaining to preconception and interconception health.

Monitoring: Document efforts with partners and document initiatives DSHS is involved with pertaining to preconception and interconception health.

**D. State Performance Measures**

**State Performance Measure 1:** *Change in percentage of CYSHCN living in congregate care settings as percent of base year 2003.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	90	90	85	85	80
Annual Indicator	99.4	100.4	97.8	97.0	94.6
Numerator	1608	1624	1582	1568	1530
Denominator	1617	1617	1617	1617	1617
Data Source		Permanency Planning and	Permanency Planning and	Permanency Planning and	Permanency Planning and

		Family Based Alt. Report	Family Based Alt. Report	Family Based Alt. Report	Family Based Alt. Report
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	80	80	80	80	80

**Notes - 2011**

Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2011. The report contains data ending August 31, 2011.

The FY11 number decreased from the base year 2003. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments. Although the number of children in Intermediate Care Facilities/Mental Retardation decreased slightly, there was an increase in the number of children in Home and Community-Based Service facilities.

**Notes - 2010**

Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2010. The report contains data ending August 31, 2010.

The FY10 number decreased from the base year 2003. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments. Although the number of children in Intermediate Care Facilities/Mental Retardation decreased slightly, there was an increase in the number of children in Home and Community-Based Service facilities.

**Notes - 2009**

Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature February 2010.

The FY09 number decreased from the base year 2003. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments. The number of children in Intermediate Care Facilities/Mental Retardation remained steady with slight decreases in other facility types.

**a. Last Year's Accomplishments**

Activity 1: CSHCN SP regional staff and contractors assisted 1,786 CYSHCN and their families with permanency planning. HHSC Senate Bill (SB) 368 Permanency Planning Report noted that 1,530 children resided in institutions for the six-month period ending August 31, 2011. Of these, 593 children were recommended for transition to the community. During the reporting period, 128 children moved to family-based settings and 153 children moved to other less restrictive environments. Residential settings for children continued to shift to smaller, less restrictive environments.

CSHCN SP contractor, EveryChild, Inc., expanded its study of CYSHCN residing in institutions and identified promising practices and solutions from literature and other states' practices. Findings were used to educate key stakeholders and state agency leaders on institutional alternatives through provision of services to families focused on behavior supports, dual diagnoses, trauma-informed care, crisis prevention, and treatment-based foster care.

Activity 2: Contractors provided family support services to 1,922 children and families and 104,815 respite hours. CSHCN SP provided a health care benefit for 1,872 children. Contractors operated loan closets, hosted conferences, fostered parent-to-parent connections, expanded respite programs to new geographic areas, and provided funds for equipment, supplies, and counseling to support children living at home.

CSHCN SP contractor, SHARE, developed a mentoring program for siblings of CSHCN to participate as youth helpers in SHARE's center-based respite program. Participants were recognized during the Annual Sibling Celebration. Children's Special Needs Network partnered with the Aging and Disability Resource Center and Lifespan Respite program to expand respite services for families.

DADS' Texas Respite Coordination Center (TRCC) hosted respite care stakeholder forums across Texas to raise awareness of respite care in the community. Topics included respite care for children, outreach to the Hispanic community, and resource development in rural areas. Staff and two contractors are members of the Texas Respite Coalition, an advisory group to the TRCC. Staff provided input to the TRCC's Take Time Texas marketing campaign and website under construction that will feature a statewide directory of respite services.

Activity 3: Staff assisted in the early development of various workgroup report recommendations for the 83rd legislative session. Staff assisted in developing HHSC's "Feasibility Study for Providing Community Support and Residential Services for Individuals with Acquired Brain Injury," which recommended halting admission of children to state schools and resulted in an LAR exceptional item.

Staff participated in the Children's Policy Council, Task Force for Children with Special Needs, Consumer-Directed Services Workgroup, Promoting Independence Advisory Council, Texas Respite Coalition, and Texas Council for Developmental Disabilities interagency workgroups. Contractors and regional staff participated in community forums, committee meetings, and CRCGs to promote and improve community-based services for CYSHCN. Staff trained contractors on permanency planning and related activities to strengthen support for families in preparing youth for adulthood.

The 82nd Legislature directed DADS to implement utilization reviews, cost-containment initiatives, and caps in Medicaid Waivers. Reduced funding for the ECI program resulted in narrowing eligibility criteria.

Performance Assessment: 1,530 children resided in institutions, 94.6% of the 2003 baseline number of 1,617, representing a decrease of 2.4% from FY10. The total number of children in institutions as defined by Senate Bill 368 remained fairly steady and residential settings continued a shift to smaller, less restrictive environments. Barriers to living successfully in the community with families included inadequate community supports, medical services, attendant care, behavioral intervention, and respite. CSHCN SP endorses permanency planning principles to support CYSHCN living with families in communities.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide and assess the provision of permanency planning services to families of CYSHCN who reside in or are at risk of placement in congregate care settings.		X		
2. Fund and promote respite and other family support services through contracts, CSHCN SP health care benefits, and collaboration with other entities.		X		

3. Collaborate with public and private entities to support permanency planning and family-based living options for CYSHCN who reside in or are at-risk of placement in congregate care settings.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: CSHCN SP regional staff and contractors assisted 991 CYSHCN and their families with permanency planning activities.

EveryChild, Inc. continued educating key stakeholders and agency leadership from findings of a previously funded CSHCN SP project identifying promising alternatives to congregate care for the high percentage of Texas children in institutions with dual diagnoses of developmental disabilities and mental health needs.

Activity 2: CSHCN SP contractors and health care benefits provided respite and other family support services to 1,652 children and families totaling 51,549 respite hours. In addition to hosting conferences and workshops for families, contractors also provided funds for durable medical equipment, supplies, medication, and other expenses not covered by other sources to support children living at home.

Activity 3: The Texas Respite Coalition (TRC) launched the Take Time Texas searchable respite resource database. CSHCN SP staff participated in pre-launch planning, contributed resource information, and facilitated a conference call presentation on the new website for contractors.

***An attachment is included in this section. IVD\_SPM1\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Provide and assess the provision of permanency planning activities for families of CYSHCN who reside in or are at risk of placement in congregate care settings.

Output Measure(s): Number of CYSHCN assisted with permanency planning activities by CSHCN SP regional and contractor case management staff; information from HHSC Permanency Planning and Family-Based Alternatives (FBA) Report (Senate Bill 368); number of children living in congregate care settings; number of permanency plans completed by DADS and DFPS for children living in congregate care settings; number of children living in congregate care settings recommended for transition to the community; number of children leaving institutions; placement in a family-based setting; placement in less restrictive environment other than a family-based setting; trends in admission, discharge, and placement.

Monitoring: Review quarterly regional activity and contractor quarterly reports, and data from the HHSC Permanency Planning and FBA Report.

Activity 2: Fund and promote respite and other family support services through contracts, CSHCN SP health care benefits, and collaboration with other entities.

Output Measure(s): Number of respite and other family support programs funded and promoted through CSHCN SP contracts; number of CYSHCN provided respite and other family support

services through CSHCN SP contractors and health care benefits; number of total respite hours provided by CSHCN SP contractors and health care benefits.

Monitoring: Review quarterly reports from the CSHCN SP health care benefits database and contractor quarterly reports.

Activity 3: Collaborate with public and private entities to promote permanency planning, natural supports, family-based living options, and community inclusion for CSHCN who reside in or are at risk of placement in congregate care settings.

Output Measure(s): Documentation of participation in related committee, agency or organization meetings; documentation of recommendations or actions of related committee/agency meetings; reports of related contractor activities.

Monitoring: Review Stakeholder Meeting Records on relevant meetings attended by CSHCN SP staff, contractor quarterly reports, and reports of other activities.

**State Performance Measure 2: *Rate of excess feto-infant mortality in Texas.***

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					1.5
Annual Indicator		1.6	1.5	1.8	1.6
Numerator					
Denominator					
Data Source		Natality and Mortality Data			
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1.5	1.4	1.4	1.3	1.3

**Notes - 2011**

This is a Perinatal Periods of Risk (PPOR) measure. PPOR is an approach to monitoring and investigating feto-infant mortality utilized by the CDC and WHO, among others. The rate of excess feto-infant deaths is the rate of feto-infant deaths in Texas minus the rate among a reference group of non-Hispanic white women, aged 20+ with 13+ years of education.

Calculations use the 1998-2000 external national reference group value of 5.9/1,000 live births <http://webmedia.unmc.edu/community/citymatch/PPOR/NationalDataTables98-00/Table6.pdf> (includes non-Hispanic white women, aged 20+ with 13+ years of education)

Natality, Mortality, and Fetal death data for 2011 are estimated. Estimates are based on a linear trend of final data from 2006-2010.

**Notes - 2010**

Update: 2010 data is final.

This is a Perinatal Periods of Risk (PPOR) measure. PPOR is an approach to monitoring and investigating feto-infant mortality utilized by the CDC and WHO, among others. The rate of

excess fetoinfant deaths is the rate of fetoinfant deaths in Texas minus the rate among a reference group of non-Hispanic white women, aged 20+ with 13+ years of education.

#### **Notes - 2009**

Update: 2009 data is final

This is a Perinatal Periods of Risk (PPOR) measure. PPOR is an approach to monitoring and investigating fetoinfant mortality utilized by the CDC and WHO, among others. The rate of excess fetoinfant deaths is the rate of fetoinfant deaths in Texas minus the rate among a reference group of non-Hispanic white women, aged 20+ with 13+ years of education.

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

Activity 1: Staff attended a 2-day CityMatCH Perinatal Periods of Risk (PPOR) Workshop. State and regional phase I analyses were completed for years 2005-2008. There were an estimated 4,213 excess fetoinfant deaths. The PPOR map indicated that 1,807 excess deaths were attributable to maternal health/prematurity, 897 to maternal care, 427 to newborn care, and 1,081 to infant health.

Activity 2: Distribution of excess death was mapped by race/ethnicity and was also calculated at the health service region (HSRs) and, where numbers were large enough, the county and metro-statistical area levels. Notable disparities in excess fetoinfant death for black infants were observed. Blacks had the highest excess fetoinfant mortality (FIM) rate for each of the 4 risk periods, maternal health/prematurity (MHP), maternal care (MC), newborn care (NC), and infant health (IH). Potentially, 61% of Black fetal and infant deaths were preventable. For Blacks, 51% of the overall excess deaths occurred in the Maternal Health/Prematurity risk period, with an excess rate 8 times that of Whites. For teens, 80% of excess deaths occurred in the Maternal Health/Prematurity and Infant Health risk periods (40% each). In the Infant Health risk period, the rate of excess FIM among Blacks was 2.8 times that of Whites and 5 times that of Hispanics.

Most FIM in the MHP period is attributable to a greater number of VLBW births to Blacks, Whites, and teens, with 100% of deaths to Blacks attributed to excess VLBW and associated mortality. Hispanic deaths are primarily due to higher mortality rates (56.1%) at specific VLBW birth weight categories. Risk factors contributing most to incidence of VLBW included weight gain less than 15 lbs., no first trimester prenatal care, inadequate prenatal care, and teen pregnancy. Blacks, Hispanics, and teens had higher prevalence of inadequate prenatal care, and Blacks had higher rates of premature rupture of membranes.

Birth defects were the primary cause of death in the IH risk period, accounting for 27% of the excess deaths. Perinatal conditions (primarily disorders related to short gestation and to complications of pregnancy, labor, and delivery) contributed to 38% of excess deaths among Blacks and 39% among teens, and SIDS accounted for 27% of excess deaths among Whites. No breastfeeding at hospital discharge, inadequate prenatal care and parental smoking were risk factors contributing most to IH-related infant deaths.

Inadequate prenatal weight gain among Blacks, Hispanics, and teens and diabetes among Hispanics contributed to FIM related to the MC period of risk.

Activity 3: Findings were presented to the DSHS Title V partners meeting and discussed internally. Meetings were held to determine how PPOR findings will be further disseminated and used to inform communities in implementation of activities related to the Healthy Texas Babies Initiative.

Activity 4: Staff across the state participated and coordinated multiple infant health workgroups, committees, and partnerships; delivered five professional presentations; launched online Safe Sleep trainings delivered to all Texas Child Protective Services case workers; developed trainer's manual for smoking cessation for pregnant women, Child Fatality Review Team annual report,

and Texas Infant Sleep Survey fact sheet; continued to receive reports of Safe Sleep pilot community trainings and evaluations; distributed educational materials; and participated in drafting indicators for quality-based hospital care. Core team and project management meetings held for Healthy Texas Babies (HTB) initiative and an Expert Panel (EP) summit and follow-up meeting were convened. A document of expert panel recommendations was developed and feedback was solicited. Community, payer, and provider workgroups were convened from members of the HTB-EP and Resource Team to identify a total of six priority areas and develop action plans. Action plans were reviewed and endorsed by the HTB-EP during the July EP meeting. The EP committed to continue meeting to track progress on action plans.

Performance Assessment: The fetio-infant mortality rate (# fetio/infant deaths per 1,000 fetal deaths/live births) generally decreased from 7.8 in 2005 to a projected rate of 7.5 in 2011. The excess death rate generally declined from 1.9 in 2005 to a projected rate of 1.6 in 2011. PPOR mapping allows for resource prioritization and targeted prevention planning.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify excess fetio-infant mortality using the Perinatal Periods of Risk (PPOR) map.				X
2. Complete analyses to identify and prioritize factors with greatest contribution to fetio-infant death disparities.				X
3. Communicate findings of PPOR analyses to stakeholders.				X
4. Develop and disseminate materials and activities aimed at increasing awareness about infant health promotion and prevention of fetio-infant mortality.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: There were 2,978 fetio-infant deaths in Texas in 2009 for a fetio-infant death rate of 7.4 fetio-infant deaths per 1,000 fetal deaths/live births. Of these, 606 were estimated to be excess fetio-infant deaths for a fetio-infant excess death rate of 1.5.

Activity 2: Secondary analyses were conducted for the state, HSRs, and 23 counties with the highest Medicaid population, greatest number of preterm births and high concentration of African American residents to examine factors associated with mortality in the 3 risk periods maternal health/prematurity, maternal care, and infant health where the greatest number of excess deaths occurred and where the greatest disparities were evident.

Activity 3: Summary analyses reports were drafted. Reports were provided to select local communities to use to develop responses to a Healthy Texas Babies (HTB) Request for Applications. Availability of reports was announced to the HTB Expert Panel and reports were posted to the HTB website.

Activity 4: Staff coordinated/participated in infant health workgroups, committees, partnerships, and trainings. A Healthy Texas Babies (HTB) Workgroup was formed to operationalize Expert Panel recommendations. Committees were formed to develop implementation strategies and tools in 6 topic areas. Ten selected applicants were funded to develop HTB coalitions to implement evidence-based interventions to address infant health outcomes in their communities.

A HTB Expert Panel meeting was conducted.

***An attachment is included in this section. IVD\_SPM2\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Identify excess feto-infant mortality using the Perinatal Periods of Risk (PPOR) map.

Output Measure(s): PPOR map developed for Texas.

Monitoring: PPOR map.

Activity 2: Complete analyses to identify and prioritize factors with greatest contribution to feto-infant death disparities.

Output Measure(s): Number and type of analyses completed; method for prioritization identified; report of identified prioritized factors developed.

Monitoring: Document analyses and priorities.

Activity 3: Communicate findings of PPOR analyses to stakeholders.

Output Measure(s): Communications developed; communications disseminated; number and types of stakeholders; number and types of feedback received.

Monitoring: Document communication and feedback received.

Activity 4: In conjunction with Healthy Texas Babies and other initiatives, develop and disseminate materials and activities aimed at increasing awareness about infant health promotion and prevention of feto-infant mortality.

Output Measure(s): Public awareness, educational materials, and activities developed; dissemination methods identified; materials and information disseminated.

Monitoring: Document materials, activities, and dissemination methods; review quarterly Health Service Region reports.

**State Performance Measure 3:** *The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective					

**Notes - 2011**

The MCH survey assessing program readiness and capacity to address mental and behavioral health has not been conducted.

## **Notes - 2010**

The MCH survey assessing program readiness and capacity to address mental and behavioral health has not been conducted.

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

Activity 1: MCH staff created a survey to measure DSHS' capacity to address the integration of mental and behavioral health into MCH programs. The survey included questions intended to gather input on perceptions of staff capacity to implement evidence-based programs within their own program area, program area funding and resources, leadership and support of the use of evidence-based practices, programs and/or strategies, the amount of evaluation and data support program areas have and program-related partnerships and partnership support in implementing evidence-based programs. The survey was refined to ensure question clarity and intent. A timeline was established for survey development and administration.

Activity 2: OPDS subject matter experts worked with THSteps to review and provide input on the online provider training modules on developmental screening, mental health and adolescent behavioral health. The trainings are required for all THSteps providers but are available to any interested learner. The modules are updated on a regular (typically annual) basis. DSHS hosted 4 "Grand Rounds" presentations related to mental and behavioral health issues in FY11. The sessions were open to any interested learner. The MHSA Division, WIC and Texas Office for the Prevention of Developmental Disabilities participated in an effort to develop a best practice guide for providers on domestic violence. The guide is in use by the Texas Council on Family Violence. Staff attended the Perinatal HIV Consortium meetings held by the Division of Prevention & Preparedness. Title V provided funding for additional training in the area of infant mental health. Through this training opportunity 40 people were able to receive training on infant mental health topics. An Adolescent Health Guide (see attached) was developed by THSteps and the Adolescent Health Coordinator to distribute information about adolescent health care laws. It covered issues of confidential services, minor consent laws, mandatory reporting laws, and a brief overview of adolescent development. In addition, the guide provided screening questionnaires as examples of how to identify behavioral health issues or other psychosocial issues that may lead to making unhealthy decisions.

Activity 3: DSHS participated in the Texas Leadership Team and the Virtual Council, a Project Connect (PC) effort to integrate public health and violence prevention. The Women's Health Coordinator presented the results of the Best Practices (BP) survey at a PC meeting that included Federal Family Violence Prevention Fund Staff and to a group of PhD students at a vital stats meeting. PC agreed to assist with implementation and piloting of the BP. Staff consulted with the Regional CDC Assignee working along the border on violence issues. Staff presented information about the best practice guide at the Head Start Annual Conference. Work continued with Texas Fetal Alcohol Syndrome Disorder Leadership & Planning Collaborative on statewide strategic planning Goal 2. Goal 2 included work with MHSA and other partners to provide specialized education about the impact of alcohol use prior to and during pregnancy and about the available community resources for substance abuse treatment and intervention services.

Activity 4: Reproductive coercion questions were added to PRAMS and will be included in the survey starting in 2012. Texas DSHS and the Texas Healthy Start Alliance (THSA) coordinated an evaluation of screenings for perinatal depression among Healthy Start programs in the THSA and to develop a plan to improve quality in both screening protocols and data collection. The six Healthy Start sites involved adopted a standardized prenatal depression screening tool which included questions to assess prenatal domestic violence risk and will share data with DSHS for analysis.

Performance Assessment: Although Performance Indicator Data has not been reported, ongoing efforts to complete baseline survey have been continued in FY12. Staff turnover and a hiring

freeze has posed a significant challenge to this new measure.

**An attachment is included in this section. IVD\_SPM3\_Last Year's Accomplishments**

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess current level at which programs are working to enhance statewide capacity to address mental and behavioral health for MCH population.				X
2. Develop cross divisional opportunities for programs to increase capacity in addressing mental and behavioral health in MCH populations.				X
3. Partner with internal and external partners to enhance and incorporate mental and behavioral health for MCH populations into their efforts.				X
4. Increase opportunities to enhance and improve the quality of the data sources related to mental and behavioral health.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: The survey to measure DSHS' capacity to address the integration of mental and behavioral health into MCH programs is currently being refined to ensure question clarity and intent.

Activity 2: Staff assisted THSteps in reviewing final content for a module titled "Mental, Emotional and Behavioral Disorders". DSHS hosted two "Grand Rounds" presentations related to mental and behavioral health issues -- one on suicide and one related to aging and wellbeing.

Activity 3: DSHS continued to work with Project Connect (PC) to integrate public health and violence prevention. Work continued with Texas FASD Leadership & Planning Collaborative on the state goals. Goal 2 includes work with MHSA and other partners to provide specialized education about the impact of alcohol use prior to and during pregnancy and about the available community resources for substance abuse treatment and intervention services.

Activity 4: THSA are coordinating the evaluation of screenings for perinatal depression among Healthy Start programs in the THSA and develop a plan to improve quality in both screening protocols and data collection. Texas DSHS has worked closely over the past year to develop a standard protocol for data collection for Texas Healthy Start sites. DSHS has implemented a more robust set of quality indicators on the Perinatal Depression study, standardized the download schedule of data from the study and is working on finalizing a consent process to improve data collection.

**An attachment is included in this section. IVD\_SPM3\_Current Activities**

**c. Plan for the Coming Year**

Activity 1: Assess current level at which programs are working to enhance statewide capacity to address mental and behavioral health for MCH population.

Output Measure(s): Number of surveys distributed to MCH programs; number and type of MCH programs responding to survey; assess what has already been accomplished by the Mental Health Transformation work group efforts and other efforts around the agency.

Monitoring: Review of annual survey results.

Activity 2: Develop cross divisional opportunities for programs to increase capacity in addressing mental and behavioral health in MCH populations.

Output Measure(s): Number of cross divisional partnerships; number and type of activities implemented.

Monitoring: Summary of partnerships and activities.

Activity 3: Partner with internal and external partners to enhance and incorporate mental and behavioral health for MCH populations into their efforts.

Output Measure(s): Number of meetings and types of partners engaged; number and type of activities implemented.

Monitoring: Document meetings or plans developed with partners.

Activity 4: Increase opportunities to enhance and improve the quality of the data sources related to mental and behavioral health.

Output Measure(s): Number of data sources that collect information about mental and behavioral health.

Monitoring: Use of data in reports, grants, and other documents; review quarterly Health Service Region reports.

**State Performance Measure 4:** *The percent of women between the ages of 18 and 44 who are current cigarette smokers.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	17	16.5	16	15.5	14.5
Annual Indicator	18.1	15.7	15.0	12.5	12.7
Numerator	846808	743014	720955	618039	638417
Denominator	4666871	4732576	4806369	4937333	5026892
Data Source		Behavioral Risk Factor Survey			
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual	12.5	12.5	12	12	11.5

Performance Objective					
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**Notes - 2011**

BRFSS is a sample survey, therefore, the numerator and denominator are not available. The annual indicator is the point estimate of the data collected after weighting. Numerator data are calculated by multiplying the percent from BRFSS and the total number of women 18 to 44 years of age. BRFSS data for 2011 is estimated. Estimates are linear projections based on data from 2006 through 2010. Denominator data is projected by the Office of the State Demographer.

**Notes - 2010**

BRFSS is a sample survey, therefore, the numerator and denominator are not available. The annual indicator is the point estimate of the data collected after weighting. Numerator data are calculated by multiplying the percent from BRFSS and the total number of women 18 to 44 years of age.

**Notes - 2009**

This indicator has been adjusted for final data. BRFSS is a sample survey, therefore, the numerator and denominator are not available. The annual indicator is the point estimate of the data collected after weighting. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by multiplying the percent from BRFSS and the total number of women 18 to 44 years of age.

**a. Last Year's Accomplishments**

Activity 1: The Yes You Can Quitline TV campaign ran from December 27, 2010 through January 30, 2011 in Austin, Lubbock, and San Antonio. The target audience was adults ages 25-49. A total of 1,254,242 adults between the ages 25-49 (73.7% of the target market) were exposed to the commercials an average of 3.9 times for 4,634,179 total impressions. Cable television was utilized for the Fort Bend market, using the Katy, Sugarland, and Fort Bend cable systems for adults between the ages 25-49. It is estimated that 55.1% of the target audience (79,091 adults between the ages 25-49) was exposed to the message an average of 2.9 times for 229,726 total impressions.

Activity 2: Tobacco Prevention and Control Program (TPCP) offered telephone cessation counseling to residents of selected targeted communities and counseling plus nicotine replacement therapy to those who are uninsured or pregnant statewide. All other residents of Texas receive a web-based cessation coaching service. The TPCP works with funded and unfunded coalitions around the state to promote tobacco prevention activities that range from educating youth and adolescents about the hazards and issues surrounding tobacco use to working to create environmental changes to support clean indoor air policies.

DSHS staff and contractors worked to provide cessation counseling and nicotine replacement therapy to pregnant women who were receiving in-patient treatment services for their substance abuse addiction. This initiative allowed women to be able to kick their tobacco habits while also addressing addictions of alcohol and other drugs. Cessation counseling began while the women were still in-patient and continued after the women were released so that there was continuity in care as these clients returned to their homes and communities. This initiative provided a framework for a substance abuse treatment cessation initiative that was included in a funding request to the Cancer Prevention and Research Institute of Texas to begin in 2012.

Activity 3: According to 2010 PRAMS data, approximately 6.0% of teens of all races between the ages of 13-19 smoked in the last three months of pregnancy. For women of all races over the age of twenty, approximately 7.1% smoked in the last three months of pregnancy. When examined by race, Whites have the highest rates in the teen age group (13-19), with approximately 13.7% smoking in the third trimester. Approximately 7.4% of Black women and 13.8% of White women over the age of 20 smoked in the last three months of pregnancy. In the 3 months before

pregnancy, the percent of women between the ages of 18-44 who smoked was approximately 19.1%. The rates were much higher for Whites (30.0%) than for Blacks (20.7%) and Hispanics (11.4%). While approximately 11.4% of women aged 18-44 smoked in the 3 months after pregnancy, rates were higher for Whites (19.7%) than Blacks (17.4%) and Hispanics (5.6%).

Performance Assessment: Provisional data indicates that the percentage of women ages 18-44 who are cigarette smokers according to the 2010 BRFSS was 12.7%. This is a slight increase from the rate of 12.5% in 2010; however, this percentage remains lower than the annual performance objective of 14.5%.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide smoking cessation training using the Yes You Can Clinical Toolkit to healthcare professionals using Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Center staff.			X	
2. Distribute cessation and secondhand smoke educational materials through Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Centers.			X	
3. Monitor smoking rates among women age 18-44 by race and ethnicity and by pregnancy status through the analysis of previously collected surveillance data.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: DSHS received 604 clinician referrals to the Texas Quitline where approximately 60% of those served are women and approximately 40% of those served are between the ages of 18 and 40. Regional staff and coalition partners continued to reach out to healthcare providers with information on best practices for treating tobacco dependence and disseminate an evidence-based module for treating tobacco dependency for use in electronic or paper health records.

Activity 2: DSHS tobacco coalitions made 1,473 consultations regarding cessation to healthcare providers and worksites within targeted communities. During these consultations, information and resources on cessation were provided to the provider or worksite contact. In addition, there were 4,691 hits on the YesQuit.org web site from 3,476 unique individuals.

Activity 3: The 2010 Texas BRFSS reports that women continue to smoke below the state average. Current smoking prevalence is 15.8% overall and 13.4% for women in 2010. Comparatively, smoking prevalence in 2002 was 22.9% overall and 19.2% for women. Of the women who received services from the Texas quitline during this reporting period, 51 were currently pregnant, 27 were planning to become pregnant within 3 months of contacting the quitline and 4 were currently breastfeeding.

***An attachment is included in this section. IVD\_SPM4\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Provide tobacco cessation resources and support to partners working on efforts to improve maternal and child health.

Output Measure(s): Number of trainings held; number of resources distributed; number of referrals to Quitline by partners.

Monitoring: Quarterly total of training sessions held; resources distributed; and Quitline referrals made.

Activity 2: Distribute cessation and secondhand smoke educational materials through Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Centers.

Output Measure(s): Number and type of materials distributed. Monitoring: Number of materials distributed and the number of hits to yesquit.org website.

Activity 3: Monitor smoking rates among women age 18-44 by race and ethnicity and by pregnancy status through the analysis of previously collected surveillance data.

Output Measure(s): Percent of women aged 18-44 who smoke by race and ethnicity, percent of women who smoked prior to pregnancy, percent of women who smoked during pregnancy, and percent of women who smoke in the postnatal period.

Monitoring: Review birth record, PRAMS, and Texas BRFSS data as available.

**State Performance Measure 5:** *The percent of obesity among school-aged children (grades 3-12).*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					38
Annual Indicator		37.1	39.3	39.4	39.4
Numerator		1432960	1529673	1508282	1525595
Denominator		3865559	3894222	3831601	3870381
Data Source		School Physical Activity & Nutrition Survey			
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	38	37	37	36	36

**Notes - 2011**

School Physical Activity & Nutrition Survey (SPAN) is a sample survey. The annual indicator is the point estimate of the data collected after weighting.

Numerator data are calculated by multiplying the percent of 4th, 8th, and 11th grade student children who are overweight or obese from SPAN survey and the total number of school-aged children. Fourth grade estimates were applied to all elementary school-aged children (ages 8 through 11). Eighth grade estimates were applied to all middle school-aged children (ages 12 through 14). Eleventh grade estimates were applied to all high school-aged children (ages 15 through 18). Numerator percents applied to total population are based on the SPAN 2009-2011 Survey.

Population (Denominator) data are projections from the Office of the State Demographer.

#### **Notes - 2010**

School Physical Activity & Nutrition Survey (SPAN) is a sample survey. The annual indicator is the point estimate of the data collected after weighting.

Numerator data are calculated by multiplying the percent of 4th, 8th, and 11th grade student children who are overweight or obese from SPAN survey and the total number of school-aged children. Fourth grade estimates were applied to all elementary school-aged children (ages 8 through 11). Eighth grade estimates were applied to all middle school-aged children (ages 12 through 14). Eleventh grade estimates were applied to all high school-aged children (ages 15 through 18). Numerator percents applied to total population are based on the SPAN 2009-2011 Survey.

Population (Denominator) data is based on Census 2010 data.

#### **Notes - 2009**

School Physical Activity & Nutrition Survey (SPAN) is a sample survey. The annual indicator is the point estimate of the data collected after weighting.

Numerator data are calculated by multiplying the percent of 4th, 8th, and 11th grade student children who are overweight or obese from SPAN survey and the total number of school-aged children. Fourth grade estimates were applied to all elementary school-aged children (ages 8 through 11). Eighth grade estimates were applied to all middle school-aged children (ages 12 through 14). Eleventh grade estimates were applied to all high school-aged children (ages 15 through 18). Numerator percents applied to total population are based on the SPAN 2009-2011 Survey.

Denominator data is from the Office of the State Demographer.

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

Activity 1: Data collection for the SPAN survey was completed in the first quarter of FY11. 398 schools participated. Over 11,000 students and almost 3,000 matched parent surveys were completed. DSHS and the Dell Center for Healthy Living have discussed findings from the data analysis and possible implications for future policy and program development.

Activity 2: DSHS Nutrition, Physical Activity, and Obesity Prevention (NPAOP) and School Health Program coordinated with Texas AgriLife Extension, Texas Education Agency (TEA) and the HHSC Center for Elimination of Disproportionality and Disparities (CEDD) on the ARRA/Communities Putting Prevention to Work (CPPW) Component I obesity project. This project promotes evidence-based policies and interventions at the state and local levels to establish healthy social norms, provide healthier, affordable choices, and institutionalize healthy behaviors. Elementary schools provide community hubs for fresh produce and free physical activity. Schools sites implemented the project and have discussed joint use agreements to increase after hours access to the school. In FY11, 600 people were served in 8 schools through presentations, workshops and trainings. NPAOP also worked with the schools to create banners to promote their initiatives and 7 out of 8 schools agreed to order and install signage.

Activity 3: The School Health Program published & distributed 48 issues of the "Friday Beat", a weekly e-newsletter providing various topics of information relating to school health to over 62,800 individuals. The Texas School Health Network distributed information related to childhood obesity prevention, nutrition, and physical activity through the "Friday Beat" to 503,374 individuals across Texas. Additionally, the Texas School Health Network distributed other resources related to school-aged childhood obesity through other venues including workshops, awareness presentations, site visits and technical assistance. Through these methods they distributed 69,625 materials to 55,852 individuals across Texas. In addition, the DSHS funded school based health centers provided screenings, treatment and follow up to 203 students with concerns about weight management.

Activity 4: DSHS regional staff worked with community and school initiatives, including local coalitions, county extension services, child care centers, summer camps, and SHACs to promote obesity prevention, physical activity, improve school menus, assist in the development of community gardening and farmers markets, and provide worksite wellness information and programs. They shared data and participated in obesity prevention activity planning at over 500 meetings.

NPAOP, OTV&FH, and the Office of Border Health provided funding to 5 community organizations to address physical activity, nutrition policy and environmental change. Brazos Valley installed signs for the city of Bryan's downtown walking circuit. Community Council of Greater Dallas negotiated infrastructure changes with the City of Dallas which included repainting lines, crosswalks, stop bars, and installing directional arrows and sidewalks at busy intersections around schools and grocery stores. Texas A&M installed a walking track between two elementary schools and installed 7 solar lights surrounding the track. Teaching & Mentoring Communities (TMC) Wellness Policy, including increasing physical activity and limiting screen time, was reviewed and finalized, including Spanish translation, and forwarded to a TMC committee in order to be introduced to Policy Council. Texas State University worked with local restaurants to implement healthy kids menus in San Marcos. As of August 31, 2011, 65 restaurants out of 131 contacted offered Best Foods FITS menu options.

Performance Assessment: Texas rates indicate approximately 1/3 of our school-aged children are overweight/obese and rates still remain above the HP 2020 targets. DSHS continues to implement activities which include promoting evidence-based policies and interventions through elementary schools focused on healthy eating and physical activity, providing training and education, and funding school-based health centers to assist staff in screening students with weight concerns.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the School Physical Activity Nutrition (SPAN) workgroup to examine demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th grade children and their parents, 8th graders and 11th graders.				X
2. Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent school-aged childhood obesity.				X
3. Disseminate information and resources about the prevalence and risk factors associated with school-aged childhood obesity.			X	
4. Coordinate and implement regional and local childhood obesity prevention activities.			X	
5.				

6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: Data have been analyzed and indicate that the prevalence of obesity in children in grades 4, 8, and 11 was 23.8, 23.0, and 21.6% respectively. Regional fact sheets have been developed and will be disseminated. Plans are being developed to further analyze and disseminate these findings.

Activity 2: NPAOP continued work on the ARRA/CPPW Component I obesity project. Staff worked with AgriLife, school staff and community members to finalize action plans for the 8 participating schools. Many schools have started implementing their projects.

DSHS regional staff worked with community and school initiatives to promote nutrition, physical activity and provide worksite wellness programs. Staff shared relevant data or participated in obesity prevention activity planning at about 300 meetings.

Activity 3: The Prevention & Preparedness Division released 12 issues of the Friday Beat, received by over 6,400 individuals weekly.

The school health specialists distributed information related to childhood obesity prevention, nutrition, and physical activity to 69,219 individuals across Texas. School-based health centers have provided services on obesity to 123 students.

Activity 4: NPAOP is funding initiatives to address obesity for children in 5 communities across the state. Activities support availability of healthy food choices in public venues, safe, public spaces for breastfeeding mothers, and the installation of new playgrounds to encourage physical activity.

***An attachment is included in this section. IVD\_SPM5\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Collaborate with the School Physical Activity Nutrition (SPAN) workgroup to examine demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th grade children and their parents, 8th graders and 11th graders.

Output Measure(s): Prevalence of overweight and obesity among Texas school children by grade, gender and race/ethnicity; analysis to identify sociodemographic, social, and mental health correlates of obesity.

Monitoring: Number of meetings to review study progress and outline dissemination activities.

Activity 2: Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent school-aged childhood obesity.

Output Measure(s): Number and type of activities implemented.

Monitoring: Quarterly review of implemented activities and overall progress.

Activity 3: Disseminate information and resources about the prevalence and risk factors associated with school-aged childhood obesity.

Output Measure(s): Number, type, and format of materials provided.

Monitoring: Quarterly review of information and resources distributed.

Activity 4: Coordinate and implement regional and local childhood obesity prevention activities.

Output Measure(s): Number and type of activities coordinated or implemented by Health Service Region Staff; number of childhood obesity prevention activities provided through the Education Service Centers.

Monitoring: Review quarterly Education Service Center progress reports; review quarterly Health Service Region reports.

**State Performance Measure 6:** *Rate of preventable child deaths (0-17 year olds) in Texas.*

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					14
Annual Indicator		14.1	14.5	11.5	11.5
Numerator		917	954	831	825
Denominator		6495224	6557436	7245842	7179876
Data Source		Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	11.5	11	11	11	10.5

**Notes - 2011**

Mortality data reported for 2011 is estimated. Estimates are linear projections based on data from 2006 through 2010.

Denominator data is projected by the Office of the State Demographer.

**Notes - 2010**

Update: 2010 death data is final.

Denominator is provided by the Office of the State Demographer. Data is based on the 2010 Census data.

**Notes - 2009**

Update: 2009 death data is final.

Denominator data is provided by the Office of the State Demographer.

**a. Last Year's Accomplishments**

Activity 1: CFRT experienced considerable growth this year. New teams were formed in Wood/Rains, Hardin and Van Zandt counties. The Walker County CFRT resumed reviewing and conducting prevention activities under new leadership. The Victoria County CFRT opened their review process to 4 additional counties that were without CFRT: Dewitt, Goliad, Karnes and Lavaca. The Hill Country CFRT (composed of 7 counties) had ceased to review, but were revitalized with new leadership and resumed reviews. Inquiries were made about re-starting teams in Brazoria, Fayette and Gregg counties. Requests were made to conduct community meetings for a new team composed of Brown, Coleman, Comanche and Mills counties and a new team in Fayette County. Interested parties from those re-starting and new counties were invited to attend the CFRT summer regional workshops held throughout the state. At the end of the year, there were 71 teams covering 198 counties. 93.5% of Texas children were living in communities with CFRT. Fifteen prospective teams were in development.

Activity 2: There was a strong emphasis on collection, data entry and interpretation of child fatality review data at the summer regional workshops. Training was provided based on the 2010 CFRT Annual Report aggregate data. At 8 workshop sites (Round Rock, San Antonio, McAllen, The Woodlands, Nacogdoches, Arlington, Odessa, and Amarillo), attendees were provided fact sheets about the state CFRT data as well as regional CFRT data. Issues of regional performance and data quality were also addressed. The formation of the Data Quality Workgroup was presented to all 316 workshop attendees, and volunteers for the Data Quality Workgroup were recruited and began meeting in Fall 2011.

Activity 3: All 316 attendees at the eight summer regional workshops were provided training on drowning prevention from members of local drowning prevention coalitions. As a result of the training provided, the Heart of Texas CFRT planned to organize a water safety coalition in Central Texas. Through identifying local experts to provide training, the concept of the Statewide Drowning Prevention Task Force was presented to a wide audience and potential members were identified. Four external members of the task force were identified as well as four internal members.

Activity 4: Election of the medical examiner who serves as the Texas Lead of the CDC-trained Sudden Unexpected Infant Death Investigation (SUIDI) Training Team to the State Child Fatality Review Team (SCFRT) Committee has reinvigorated the discussion about the challenges in training and implementing SUIDI in such a large state as Texas. The Child Protective Services Special Investigators (all former law enforcement officers) expressed interest in being part of the workgroup as have law enforcement representatives on local teams and the SCFRT Committee.

Performance Assessment: Preventable child deaths in Texas continue to decrease from 2009 to 2011. The number of CFRTs has increased over the last few years. These teams have provided education and training to conduct reviews, collect data and conduct injury and death prevention activities in their communities. With continued development of more CFRTs and promotion of prevention activities on the state and local levels, preventable child deaths in Texas should continue to decrease.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand Child Fatality Review (CFR) to cover more children in Texas to increase the understanding of risk and protective factors.				X
2. Develop and implement a plan to increase the number of preventable child deaths reviewed, to improve the quality of the CFR data collected and analyze data for recommendations of				X

prevention activity direction, and other methods of dissemination.				
3. Organize and facilitate internal and external stakeholders to address prevention of child drowning deaths.				X
4. Organize and facilitate internal and external stakeholders to address standardization of infant death scene investigations.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: Inquiries about forming 3 CFR teams were made. Two new teams began reviewing deaths in first half of FY12. One team is preparing an interagency agreement to begin work. One team incorporated four more counties. There are 73 CFRT covering 206 counties. 94.1% of children live in a county with a CFR process.

Activity 2: Data Quality Workgroup (DQW) meets monthly to work on problem areas to be addressed by changes in policy and practice and guidelines for users to improve data collection and data entry and strategies to increase number of deaths reviewed. DQW worked on faster access to death certificates, record access, assignment of deaths with undetermined manner, understanding which fields are not entered and why, and defining a minimal data set. DQW conducted a survey of database users to better understand user issues. DQW developed protocol for expedited review of natural deaths.

Activity 3: The idea of a State Drowning Prevention Task Force was presented to a wide audience and 8 potential task force members were identified. More was learned about the lack of coordination between different drowning prevention coalitions and past organizational obstacles.

Activity 4: Sudden Unexpected Infant Death Investigation (SUIDI) Team discussed challenges in training and implementing SUIDI in a large state. DFPS is part of the statewide effort. Materials from Tennessee child death scene investigation initiative were reviewed.

***An attachment is included in this section. IVD\_SPM6\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Expand Child Fatality Review (CFR) to cover more children in Texas to increase the understanding of risk and protective factors.

Output Measure(s): Numbers of inquiries about new teams; CFR presentations conducted; number of newly-formed teams that review fatalities; number and type of activities coordinated or implemented by Health Service Region Staff.

Monitoring: Quarterly review of number of teams and percentage of children living in counties with CFR; review quarterly Health Service Region reports.

Activity 2: Develop and implement a plan to increase the number of preventable child deaths reviewed, to improve the quality of the CFR data collected and to analyze data for Annual Report for recommendations of prevention activity direction, and other methods of dissemination.

Output Measure(s): Form Data Quality Workgroup in State CFRT Committee; create and disseminate Data Quality Plan; number of trainings on data collection and quality delivered; and use of data in Annual Report, fact sheets, presentations, reports and displays.

Monitoring: Quarterly review of data submitted shared with Data Quality Workgroup and SCFRT; data collection and quality issues addressed with teams in quarterly reports.

Activity 3: Organize and facilitate internal and external stakeholders to address prevention of child drowning deaths.

Output Measure(s): Number of contacts made with local coalitions; number of meetings with drowning prevention coalitions; creation and maintenance of directory of area coalitions in Texas.

Monitoring: Quarterly report on progress to organize water safety coalitions and facilitate coordination of drowning prevention efforts in Texas.

Activity 4: Organize and facilitate internal and external stakeholders to address standardization of infant death scene investigations.

Output Measure(s): Expansion of Texas Sudden Unexpected Infant Death Investigation (SUIDI) Training Team to a multi-disciplinary workgroup; number of meetings conducted; number of trainings requested; number of trainings delivered.

Monitoring: Quarterly report on progress to expand use of the SUIDI protocol in infant death scene investigations in Texas.

**State Performance Measure 7:** *The extent to which research findings and/or evidence-based practices are used to develop and improve DSHS programs serving MCH populations.*

Tracking Performance Measures

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

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective					

**Notes - 2011**

The MCH survey assessing program readiness and capacity to address mental and behavioral health has not been conducted.

**Notes - 2010**

The MCH survey assessing program utilization of research findings and/or evidence-based practices for program improvement and development has not been conducted.

**a. Last Year's Accomplishments**

Activity 1: Staff created a survey to measure DSHS capacity to address two specific areas that were identified as priorities in the 2010 Five Year Needs Assessment MCH Title V Block Grant: the use and integration of evidence/research-based practices, and the integration of mental and behavioral health into maternal and child health programs. The survey includes questions in the following areas: 1) perceptions of staff capacity to implement evidence-based programs within their own program area; 2) perceptions of program area funding and resources and how those resources are allocated to researched and evidence-based practices; 3) staff perceptions of a program area's leadership and support of the use of evidence-based practices, programs and/or

strategies; 4) perceptions of the amount of evaluation and data support program areas have; 5) program-related partnerships and the effectiveness of partnership in supporting and implementing evidence-based programs; and 6) perceptions on a program area's ability to support other organizations in implementing evidence-based programs. Final approval and an implementation plan have not been completed.

Activity 2: Staff subject matter experts and researchers worked with other DSHS programs to promote the use of research findings and/or evidence-based practices. This included programs within the Divisions of Family and Community Health Services, Prevention and Preparedness, and Mental Health and Substance Abuse. The DSHS Office of Title V and Family Health distributed a monthly update to MCH regional staff regarding recent research articles, reports, policy and practice statements, and other resources that promote the best practices with the MCH populations that address state and local performance measure topics.

DSHS also hosted Grand Rounds, a series of scholarly presentations designed to support workforce development at DSHS by encouraging a culture of learning and the integration of evidence into practice. Twelve presentations were made on topics such as preterm birth, early childhood mental health, ethics, cardiovascular disease, autism spectrum disorder, and evaluating the evidence in evidence-based practices. Grand Rounds was open to any interested learner, including employees from all five state health agencies and community partners from local health departments, community health centers, mental health centers, substance abuse centers, and university staff and faculty. Free continuing education credits were provided for several professions.

Activity 3: Staff worked with multiple stakeholders to explore opportunities to ensure that research findings/evidence-based practices were used as the primary mode of intervention or that information delivered to providers, professionals, and the general public was based on the most recent research or best practices.

Staff worked to promote worksite lactation programs to other health and human service agencies and to other targeted state agencies, including public universities. DSHS staff worked with representatives from mental health, child protective services, juvenile justice, extension services, substance abuse prevention, education and other youth-serving organizations to cultivate community-based leadership for the widespread delivery of evidence-based prevention and youth development programs.

DSHS launched the Healthy Texas Babies (HTB) initiative with supporting funds from the Texas Legislature. The HTB initiative was developed to help Texas communities decrease infant mortality using evidence-based interventions. It involves community members, healthcare providers, and insurance companies. A reduction in infant mortality will improve the health of Texas babies and mothers and has the potential to save millions of dollars in healthcare costs. Evidence-based interventions will be locally supported through coalitions in communities that have been identified at high-risk for infant mortality and preterm birth.

Performance Assessment: Although Performance Indicator Data has not been reported, ongoing efforts to complete baseline survey have been continued in FY12. Staff turnover and a hiring freeze has posed a significant challenge to this new measure.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess current level at which programs are working to identify research findings and/or evidence-based practices for improving DSHS programs serving MCH populations.				X
2. Increase cross-divisional opportunities to promote research				X

findings and/or evidence-based practices in DSHS programs serving MCH populations.				
3. Partner with external and internal stakeholders to identify opportunities to incorporate research findings/evidence-based practices.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Activity 1: The DSHS program survey is still being refined with an anticipated release in the latter half of FY12.

Activity 2: Through the HTB Initiative, DSHS staff and other state agency and community-based organizations, have worked to identify researched-based interventions and strategies. Workgroups were created to identify evidence-based strategies in the areas of fatherhood involvement, maternal mortality review, maternal transfer protocols, life planning, baby's first year (infant development), and other educational opportunities to improve outcomes related to infant mortality.

Other initiatives that address cross-divisional promotion of research and evidence-based practices include the mother-friendly worksite policy initiative, implementation of Senate Bill 1386 that requires DSHS to make a list of evidence-based suicide prevention programs available to the Texas Education Agency (TEA), and the continuation of the DSHS Grand Rounds Series that included presentations on the HTB Initiative and quality improvement initiatives.

Activity 3: Internal and external subject matter experts collaborate to develop and update materials for the THSteps Online Provider Education modules. Module provide research and evidence-based practice guidelines for 40 topic areas related to child and adolescent health. DSHS staff from HIV/STD Prevention and Adolescent Health collaborated with TEA to review evidence-based HIV Prevention curricula to recommend to school districts.

***An attachment is included in this section. IVD\_SPM7\_Current Activities***

**c. Plan for the Coming Year**

Activity 1: Disseminate findings to DSHS programs demonstrating the level at which programs are working to identify and utilize research findings and/or evidence-based practices for serving MCH populations.

Output Measure(s): Number, type, and format of activities implemented.

Monitoring: Review of annual survey results; documentation of materials/products distributed and activities completed.

Activity 2: Increase cross-divisional opportunities to promote research findings and/or evidence-based practices in DSHS programs serving MCH populations.

Output Measure(s): Number, type, and format of activities implemented.

Monitoring: Documentation of materials/products distributed and activities completed.

Activity 3: Partner with external and internal stakeholders to identify opportunities to incorporate research findings/evidence-based practices into programs.

Output Measure(s): Number of meetings and types of partners engaged; number and type of proposals developed for implementation; number and type of activities implemented.

Monitoring: Review meeting notes; copy of materials/plan developed.

## **E. Health Status Indicators**

As reported in other sections of the annual report, there are multiple efforts underway in Texas to address infant health, including the Healthy Texas Babies initiative that is focusing on reducing infant mortality, specifically reducing preterm births through community based coalitions and state partnerships involving other state agencies and the Texas Chapter of the March of Dimes. The Health Status Indicators related to infant and maternal health have been analyzed and remain key markers for the work that has begun.

In women's health, the minimal drop in 15-19 year-olds with a reported case of chlamydia is promising, however the increase in women 20-44 from 9.4 in 2007 to 12.5 in 2011, indicate need for additional interventions. In addition, while the birth rate overall has declined, births to white women over 35 increased. Efforts to ensure an understanding of the need for, and access to, preconception and interconception care are critical in addressing these issues.

Based on the data available, the morbidity and mortality rates related to unintentional injuries and those related to motor vehicle crashes among all children under 14 have decreased since the last reporting period. Legislation regarding booster seat use in 2009, and subsequent attempts to address distracted driving, swimming pool safety, and sports injuries through state legislation and policy are indicative of the state's commitment to reducing childhood injury. Through statewide efforts of Child Fatality Review Teams and other partnerships at the state and local agency levels, Title V staff encourages the development of education and outreach methods to continue progress.

The indicators related to demographic and geographic changes reflect an increased demand on health and social services since the last reporting period. Data reflect an increased number of Texans living under 200% of the federal poverty level, now at 39.4% including 50% of children under 19. There has also been an increase in the numbers of Texans accessing Medicaid and Food Stamps since the last annual report in 2011. Title V-funded efforts will remain focused on identification of opportunities to support vulnerable individuals and families in need of preventive and primary health care.

## **F. Other Program Activities**

### **FAMILY/CONSUMER PARTICIPATION**

CSHCN SP actively engages consumers and families in the decision-making process. Community-based contractors receiving funding through CSHCN SP have significant parent or parent/professional leadership and participate in advisory boards, meetings, and work groups. Family members attend and actively participate in quarterly conference calls for the Medical Home Work Group, and family member representatives from several contractors participate in bi-monthly conference calls for the Transition Team. CSHCN SP provides funding for the Leadership Education in Adolescent Health (LEAH) project at Baylor College of Medicine in

Houston which enables 50 family members from throughout the state to attend the annual LEAH transition conference. The program has strong ties with Texas Parent to Parent (TxP2P), the federally funded Family-to-Family Health Care Education and Information Center and collaborates with their efforts to educate parents and caregivers. Staff participate in the TxP2P annual conference as speakers, planners, and exhibitors. Staff work with parents and teens to execute the Teen Transition Expo which is part of the TxP2P annual conference.

Parents of CYSHCN in various geographic locations have become Family Voices representatives and are key advocates for improving access to and coordination of health and other services for CYSHCN. Regional social work staff and the program's community-based service contractors work to facilitate family access to services, promote family networking, increase family involvement in community service system development decisions, and obtain family feedback.

Consumers and family members receiving services through Title V contracted providers participated in the FY11 Five-Year Needs Assessment process through focus groups, community listening sessions, and surveys, resulting in more direct contact and enhanced response than had been historically achieved through less personal methods. Title V staff participate in a large number of statewide councils and workgroups with family member representation or leadership. DSHS regional staff attend and participate in local or regional meetings and events, which emphasize family member involvement.

## 2-1-1 TEXAS

Through a public/private collaboration of the United Way and other community-based organizations, HHSC administers 2-1-1 Texas, a toll-free, one-stop telephone resource to receive information and referrals for existing health and social services resources throughout Texas. Calls are routed to one of 25 local agencies contracted to answer calls for a certain geographic area where trained resource specialists ascertain the caller's need and assist them utilizing a comprehensive database listing of health and social services for the local area. In addition, individuals can call 2-1-1 to begin the eligibility determination process for services such as Medicaid, CHIP, and the Supplemental Nutrition Assistance Program. A searchable database of services is available to the public at <https://www.211texas.org/211/search.do>. 2-1-1 has also become an important component in Texas' disaster response. During Hurricane Ike and the recent H1N1 flu outbreak, 2-1-1 Texas quickly and efficiently shared emergency response information to assist people affected. In Texas, calls to the 1-800-311-BABY line for information on maternal and child and health are answered by 2-1-1 resource specialists. In FY09, 2-1-1 Texas handled over 2.4 million calls. Approximately 130,000 of these calls were categorized, according to the taxonomy guidelines, as related to maternal and child health. The top category was for dental care, with more than 14,000 calls.

## CHILD FATALITY REVIEW

Title V staff coordinate the work of the State Child Fatality Review Team (SCFRT) Committee, a statutorily-defined multidisciplinary group of professionals who serve to: develop an understanding of the causes and incidences of child deaths in Texas; identify procedures within the agencies represented on the committee to reduce the number of preventable child deaths; and promote public awareness and make recommendations for changes in law, policy, and practice to reduce the number of preventable child deaths. The SCFRT Committee works closely with local child fatality review teams (CFRTs) from across the state. These local CFRTs conduct the actual reviews, provide data on all reviews, and identify local child safety issues. In submitting local data, local teams together create a detailed picture of child death as a public health issue in Texas. The SCFRT Committee reviews the data collected statewide to develop position statements and make recommendations for policy change.

Texas currently has 63 CFR teams that serve 187 counties. There were 506,526 children residing in counties that did not have a CFRT team in 2008 (7.80% of the total population). The remaining

5,988,698 children (92.2%) live in a county that has CFRT coverage.

***//2013/ Texas currently has 68 CFRTs that serve 197 counties. Based on 2009 child population data, there were 6,136,001 children (93.57% of the total population) living in a county that has CFR coverage. The remaining 421,435 children (6.43%) live in a county that has no CFR coverage. //2013//***

#### SAFE SLEEP

The Infant Health Workgroup, comprised of DSHS MCH staff and DFPS staff in the areas of Child Protective Services (CPS) Investigations, Child Care Licensing, and the Division of Prevention and Early Intervention, was recently formed to address activities related to infant health, including safe sleep. A subcommittee of this workgroup developed a community-based training on safe sleep for infants for use by anyone who works with parents -- professionals, paraprofessionals and lay workers. Another subcommittee worked with a social marketing firm to develop a Safe Sleep Environment Assessment training which will be required of all CPS caseworkers.

Title V administers an autopsy reimbursement program mandated by Texas statute that allows counties to claim a fixed reimbursement toward the cost of an autopsy where the cause of death is determined to be Sudden Infant Death Syndrome (SIDS). The program also provides a mechanism to track data related to SIDS deaths to better understand the circumstances surrounding SIDS.

#### HOME VISITING

HHSC and DSHS leadership have designated the OTV&FH to lead the interagency collaborative process for completing the statewide needs assessment for the Maternal, Infant, and Early Childhood Home Visiting Program as required by the Patient Protection and Affordable Care Act. The home visiting needs assessment interagency workgroup, led by the Title V Director, is currently developing the required home visiting program needs assessment. Upon completion of the needs assessment, the program was transferred to the Office of Program Coordination for Children and Youth at HHSC. DSHS staff continue to support their efforts to fully implement the home visiting program.

***//2013/ HHSC received the full formula allocations for the FY10 and FY11 grants as well as a competitive development grant for FY11 for \$3.3M. It was determined that four evidence-based program models would be implemented in eight counties: Early Head Start -- Home-based Option, Home Instruction for Parents of Preschool Youngsters, Nurse-Family Partnership, and Parents as Teachers. The counties selected were based on both need and capacity to implement programs. In addition, the Positive Parenting Program will be continued in Galveston County. Contracts have been awarded to entities in each of these counties to not only implement the home visiting program models but also to develop a coordinated early childhood system, creating a local home visiting referral process, and utilizing the Early Development Instrument -- a population-based measure showing school readiness in Kindergarteners. //2013//***

### **G. Technical Assistance**

The diverse population, economy, and health needs of Texas continue to evolve in an environment for which resources remain limited, requiring an infrastructure that is effective and efficient. Consideration of the technical assistance needs listed in Form 15 will enhance the state's efforts to meet the needs of the MCH population.

#### ORAL HEALTH

Technical assistance is requested as Texas continues to search for best practices related to

providing and promoting preventive oral health care, training options for providers on oral health screening and care for young children, and enhancing awareness of caregivers about the importance of early preventive oral health care.

Increasing access to dental care was identified in the FY11 Five-Year Needs Assessment Process as one of 10 priority needs. Availability of providers including dentists was one of five most mentioned unmet needs reported in family, provider, and CRCG surveys. In 2010, 46% of the 254 Texas counties had too few dentists. Furthermore, approximately 15 million Texans live in counties with a whole or partial Health Professional Shortage Areas designation as dental shortage areas.

Agency staff have provided support for initiatives such as increasing reimbursement rates for medical and dental providers; providing specialized training to Medicaid dentists on the needs of children under the age of 3; the addition of a new billing code for dental exams for children under the age of 3 to encourage more comprehensive care, including fluoride varnish for children and counseling and education for parents. In addition efforts have been made to provide training and reimbursement for Medicaid pediatricians to perform limited oral evaluations and apply fluoride varnish to children as young as 6 months old within the medical home. Even with these activities, technical assistance is needed to identify mechanisms to further incorporate early preventive oral health care in a variety of health care settings.

#### SOCIAL DETERMINANTS OF HEALTH/LIFE COURSE PERSPECTIVE

The majority of DSHS services focus on education, technical assistance to providers, and preventive services that impact whole families. Rather than focusing on exclusively providing access to a full range of health care services, DSHS programs provide services that are designed to reach populations. Stakeholder input obtained through the FY11 Five-Year Needs Assessment process often included suggestions to ensure that services are provided in a holistic, coordinated, and culturally competent manner. Therefore, an improved understanding of the role that biological, psychological, behavioral, and social factors plays across the span of a person's life is critical to designing and administering systems for improving health outcomes for women, children, and families in this state. Technical assistance is also needed in assuring that these factors are addressed in a coordinated and comprehensive manner across DSHS program areas.

#### INTEGRATION OF MENTAL AND BEHAVIORAL HEALTH AND PRIMARY HEALTH CARE

DSHS continues to strengthen the ability of the agency to holistically address the needs of clients impacted by both physical and behavioral health issues. The Family and Community Health Services and Mental Health and Substance Abuse Divisions work with state and local advocates, consumers, families, and other stakeholders to strengthen the availability of a full array of community-based services across Texas. Technical assistance is needed regarding best practices in the areas of policy, training, and service delivery that promote integration of physical, mental, and behavioral health as Title V staff implement activities based on the new state performance measure developed for FY11 related to this effort.

#### HEALTH CARE REFORM

The Patient Protection and Affordable Care Act (HR 3590) and the Health Care and Education Reconciliation Act of 2010 (HR 4872) were recently enacted into law. Together, the laws make comprehensive reforms that are intended to increase access to health care, provide insurance protections, and improve quality of care. The new laws will significantly affect the operations and budgets of the state and local health and human service agencies. In preparation for the integration of these provisions into existing eligibility determination procedures, client services, and program operations, Title V staff may seek policy input and direction from our federal partners.

#### COMMUNITY HEALTH WORKER/PARAPROFESSIONAL PROGRAMS

The DSHS Promotora/Community Health Worker (CHW) Program coordinates the training and certification process for becoming a certified promotor(a)/CHW. As a trained peer from within communities, promotores(as) provide outreach, health education, and referrals to local community members. The CHW program coordinates the Promotor(a)/CHW Training and Certification Advisory Committee that is charged with advising the HHSC Executive Commissioner on rules related to the training and regulation of persons working as promotores(as)/CHWs. As efforts continue to expand the program within the state, examples of existing models and programs in other states, along with available training and other workforce development tools would be helpful to inform the process.

/2012/ DSHS will continue to seek guidance regarding ongoing efforts to integrate physical, mental, and behavioral health systems for MCH populations and continued development of community health worker/paraprofessional programs to address MCH needs. Additionally, DSHS will continue to seek guidance related to understanding the role of social determinants of health and the life course perspective in serving the MCH population, and opportunities for coordinating initiatives to improve birth outcomes and reduce pre-term births and infant mortality.

Region VI Title V Directors continue to explore the possibility of a regional performance measure to impact these issues. State Health Officers in Region IV and VI have come together and identified reduction of prematurity and infant mortality as priorities and are also discussing the potential of the states in these two regions identifying common measures. It would be beneficial to bring the Title V Directors and key partners from Region IV and VI together for technical assistance in developing common measures and exploring evidence-based and promising practices to impact infant mortality. Technical assistance would need to include strategies for multi-state areas that take into consideration poverty, health equity, diversity/minority health and social marketing factors. //2012//

## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> <i>(Line1, Form 2)</i>	34437266	21406399	33678798		33750193	
<b>2. Unobligated Balance</b> <i>(Line2, Form 2)</i>	8580980	15156420	9306829		14546974	
<b>3. State Funds</b> <i>(Line3, Form 2)</i>	54886980	40208728	46105185		40208728	
<b>4. Local MCH Funds</b> <i>(Line4, Form 2)</i>	0	0	0		0	
<b>5. Other Funds</b> <i>(Line5, Form 2)</i>	250000	0	290902		0	
<b>6. Program Income</b> <i>(Line6, Form 2)</i>	2527780	0	2527780		0	
<b>7. Subtotal</b>	100683006	76771547	91909494		88505895	
<b>8. Other Federal Funds</b> <i>(Line10, Form 2)</i>	605513800	588313035	626031673		554335767	
<b>9. Total</b> <i>(Line11, Form 2)</i>	706196806	665084582	717941167		642841662	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	4776187	3565947	3481486		8898022	
<b>b. Infants &lt; 1 year old</b>	57725	53083	54268		77886	
<b>c. Children 1 to 22 years old</b>	20525721	19294002	20081460		23529960	

<b>d. Children with Special Healthcare Needs</b>	51907849	38220783	44833549		42487766	
<b>e. Others</b>	16545619	11993698	17336457		6919094	
<b>f. Administration</b>	6869905	3644034	6122274		6593167	
<b>g. SUBTOTAL</b>	100683006	76771547	91909494		88505895	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	93713		133669		65357	
<b>c. CISS</b>	0		0		0	
<b>d. Abstinence Education</b>	0		0		0	
<b>e. Healthy Start</b>	0		0		0	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	581324119		598926315		528927444	
<b>h. AIDS</b>	0		0		0	
<b>i. CDC</b>	7418165		8589827		8582354	
<b>j. Education</b>	0		0		0	
<b>k. Home Visiting</b>	0		0		0	
<b>k. Other</b>						
<b>Family Plan (TitleX)</b>	0		0		16059276	
<b>NHSCPC/Male Involvem</b>	0		701336		701336	
<b>Family Planning X</b>	0		17680526		0	
<b>FamPlanning Title X</b>	15976467		0		0	
<b>NHSCPC/MaleInvolve</b>	701336		0		0	

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	73074976	52981646	68695349		61079763	
<b>II. Enabling Services</b>	5876806	4820251	5057173		5557015	
<b>III. Population-Based Services</b>	13459743	7423874	9142487		8558596	
<b>IV. Infrastructure Building Services</b>	8271481	11545776	9014485		13310521	
<b>V. Federal-State Title V Block Grant Partnership Total</b>	100683006	76771547	91909494		88505895	

**A. Expenditures**

Please note that Attachment V. A. includes the complete set of Forms 2, 3, 4, and 5 as prepared by the DSHS Grant Coordination and Funds Management Branch to provide a complete updated set of budget and expenditure data for FY08 and FY09 as of 7/12/10. Field Notes have also been added to update the individual cells of the tables where needed. The Budgeted amounts for FY11 are estimated since the federal award may change in FY11 and FY10 expenditures are not

final.

/2012/ Please note that Attachment V. A. includes the complete set of Forms 2, 3, 4, and 5 as prepared by the Grant Analysis and Policy Unit of the Budget Section of DSHS to provide a complete updated set of budget and expenditure data as of 6/24/11. Budgeted amounts for FY12 are estimated since the final Federal Allocation may change based on the FY12 federal budget and the Unobligated Balance may change as FY11 expenditures are finalized. Field notes have been updated to reflect information in individual cells as needed. //2012//

***/2013/ Please note that Attachment V. A. includes the complete set of Forms 2, 3, 4, and 5 as prepared by the DSHS Budget Section to provide a complete updated set of budget and expenditure data for FY10 and FY11 as of 6/28/12. Field Notes have also been added to update the individual cells of the tables where needed. The budgeted amounts for FY13 are estimated since the federal award may change in FY13 and FY12 expenditures are not final. //2013//***

Forms 3, 4, and 5 show variations in expenditure amounts from previous years, which are best explained by changes in available prenatal care benefits through CHIP and the impact of changes in CHIP and Medicaid eligibility. From December 2008 to December 2009, the numbers of Medicaid eligible children under age 19 grew 13% to 2,458,117. During the same period, Texas saw an 8.5% increase in monthly enrollment in the Children's Health Insurance Program (CHIP) with a steady enrollment in the state's CHIP Perinatal program that began in 2007. While these changes are positive in providing access to needed care, Title V has continued to maintain infrastructure necessary to provide prenatal care and well-child and dental care through existing contracts, primarily acting as a transitional means of obtaining care while completing the eligibility and enrollment process for CHIP or Medicaid.

#### Form 3

From FY06 to FY09, expenditures decreased from \$87 million to \$85 million even as the federal award was slightly increased in the last year. In addition to the impact of a reduction in direct services sought from Title V, there was a change in the calculation of the indirect rate applied to funding that had a substantial impact increasing available funds. As noted in the last application, the result of retrospectively applying the revised formula to client services contracts from FY07 forward resulted in a net increase in the carryforward amount of approximately \$1 million each year. While expenditures in state funds increased from \$45.8 to \$48.5 million from FY06 to FY09, the growth in carryforward funds continues. Mid-year reviews in direct services contracts have been expanded to identify potential opportunities to invest funds in agency collaborative population-based and infrastructure building projects in FY09, FY10, and FY11.

/2012/ As FY09 expenditures were finalized, the final amount of \$83 million was approximately 3% less than projected in the application submitted last year. Approximately \$1 million in federal funds and \$1.5 million in state funds were not spent. The current estimated expenditures for FY10 are just under \$92 million, however it should be noted that during FY10, state agencies were directed to implement cost containment efforts in response to projected decrease in state revenue. Strategies included implementation of in-state and out-of-state travel restrictions, reduced travel reimbursement allowances, provider reimbursement reductions, and limitations on filling vacant positions. Those strategies continued throughout FY11. It is predicted that this will impact final FY10 and FY11 expenditures. //2012//

#### Form 4

Data from FY06 thru FY09 indicate that Title V expenditures for the CSHCN population have increased from \$35 to \$42 million during that time period. The significant decrease in the expenditures for pregnant women and infants first seen in the FY10 Application continues with the reduction in expenditures from almost \$16 million in FY06 to just over \$7 million in FY09. As

previously noted, the change is tied to the increased availability of alternative sources of direct health care services as noted above. In FY09, an observed increase in expenditures for children 1-22 may be linked to the increased number of children without health insurance as noted in National Performance Measure 13.

/2012/ The expenditures for CSHCN are projected to increase again in FY10 as a result of additional children and youth being served by the agency. The expenditures for pregnant women and infants continue to decrease as a result of greater coverage of direct care services through the CHIP and Medicaid programs. In FY10, the Office of Title V & Family Health continued efforts to identify new opportunities to collaborate with other programs in the agency to build upon existing programs serving mothers, infants, children and youth. Partnerships with programs in the Divisions of Mental Health and Substance Abuse Services, and Prevention and Preparedness Services, led to planned projects that redirected funds from direct care to population-based and infrastructure building efforts. //2012//

#### Form 5

Within each year, direct services increased in FY08 and FY09 primarily from the increase in CSHCN expenditures; however, there have been slight adjustments in the other three categories of services. FY09 expenditures in Population-Based and Infrastructure Building Services increased as a result of investment in time limited projects focused on utilizing the unobligated funding from the previous period.

/2012/ As noted in Form 5, direct care service expenditures are projected to be nearly 75% of the total expenditures for FY10. It does appear that infrastructure building services are projected to continue to increase from 6% in FY08 to 10% of the total amount in FY10. Time-limited collaborative projects initiated in FY10 will continue in FY11, with the majority in population-based and infrastructure building areas. //2012//

***An attachment is included in this section. VA - Expenditures***

## **B. Budget**

### Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort (MOE) amount of \$40,208,728 as required. An additional \$6 million in state funds has been budgeted, in addition to the \$8.5 million carried forward from the FY10 award. Texas continues to exceed the state match rate of \$3 state dollars for every \$4 federal Title V dollars and provides 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.

/2012/ The commitment of general revenue for FY12 exceeds the MOE requirement by more than \$5.8 million. The final state budget appropriations in the General Appropriation Act, House Bill 1, 82nd Regular Session are being assessed and the DSHS Operating Budget for FY12 is under development. General revenue reductions in programs that have been included in the budgeted amount for MOE in previous years will be offset by identifying general revenue expenditures in other areas within the agency that serve mothers and infants, children and adolescents, and children with special health care needs. Such general revenue will only include funding that is not being claimed as a match or MOE for any other federal funds. //2012//

***/2013/ The commitment of general revenue for FY13 has been limited to the MOE requirement of \$40,208,728. The DSHS Operating Budget for FY13 is under development and a new project grant ID number has been developed specifically to identify general revenue that is deemed to meet the requirements of the MOE for the Title V grant award. In***

***FY12, as a result of legislative direction in the General Appropriations Act, House Bill 1, 82nd Legislature, Regular Session, \$6.9 million in state funds that had been previously identified as Title V MOE in the Family Planning strategy were reassigned. Appropriated General Revenue that was not used for other federal grant MOE was identified in the Immunizations Strategy and is being used for children and adolescents in the FY12-13 biennium. //2013//***

30% - 30% Federal Requirement

The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Office of Title V and Family Health requires all MCH Title V-funded contractors to provide child health services in the amount of at least 30% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on compliance with the 30% - 30% requirement on a monthly basis. The Family and Community Health Services Division and Title V program leadership review reports, provide feedback, and adjust service delivery as needed to maintain the required spending proportions.

For FY11, Form 2 shows that \$10,331,180 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional \$10,331,180 for children with special care needs. The same vigorous monitoring process described above is in place to comply with the 10% cap on administrative expenditures which are budgeted at 3,443,727 in FY11.

/2012/ The procedures described in the application submitted last year remain in place to ensure that expenditure of federal funds meets the 30/30 requirement and that the department does not exceed the administrative cap of 10%. In the FY12 projected budget, \$10,103,639 of the federal Title V funds are earmarked for children and adolescents, with the same amount noted for children and youth with special health care needs. //2012//

Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These grants include, but are not limited to: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - State Early Childhood Comprehensive Systems; 4) Centers for Disease Control and Prevention (CDC) - Breast and Cervical Cancer Early Detection Program; 5) Support State Oral Disease Prevention Program; 6) Texas Cancer Council - regional school health specialists; 7) Title X State Coordinated Family Planning Project; 8) CDC Pregnancy Risk Assessment Monitoring System; 9) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 10) Chronic Disease Prevention and Health Promotion- Obesity Component; 11) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement; and 12) CDC - Evidence-Based Laboratory Medicine: Quality/Performance Measure Evaluation; 13) CDC - Texas Early Hearing & Detection & Intervention Tracking, Surveillance & Integration; and 14) ARRA funding and potential funding that may be available through the Affordable Health Care Act.

/2012/ Current status of some funding noted above is unknown as federal awards are pending. In addition to Medicaid and CHIP funding, the following are known to be available to Texas for FY12: 1) MCHB - State Systems Development Initiative; 2) MCHB - State Early Childhood Comprehensive Systems; 3) Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Program 4) Centers for Disease Control and Prevention (CDC) - Breast and Cervical Cancer Early Detection Program; 5) Support State Oral Disease Prevention Program; 6) Title X State Coordinated Family Planning Project; 7) CDC Pregnancy Risk Assessment Monitoring System; 8) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer

Counseling); 9) HRSA Cooperative Agreement for Primary Care; and 10) CDC - Texas Early Hearing & Detection & Intervention Tracking, Surveillance & Integration; and 11) ARRA funding related to breastfeeding promotion and promotion of National Health Service Corps available through the Affordable Health Care Act . //2012//

## **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.