



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

**State Narrative for
Texas**

**Application for 2014
Annual Report for 2012**



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Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	7
C. Needs Assessment Summary	7
III. State Overview	10
A. Overview.....	10
B. Agency Capacity.....	27
C. Organizational Structure.....	37
D. Other MCH Capacity	42
E. State Agency Coordination.....	47
F. Health Systems Capacity Indicators	54
Health Systems Capacity Indicator 01:	54
Health Systems Capacity Indicator 04:	55
Health Systems Capacity Indicator 05A:.....	56
IV. Priorities, Performance and Program Activities	57
A. Background and Overview	57
B. State Priorities	58
C. National Performance Measures.....	63
Performance Measure 01:.....	63
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated	66
Performance Measure 02:.....	67
Performance Measure 03:.....	71
Performance Measure 04:.....	75
Performance Measure 05:.....	78
Performance Measure 06:.....	83
Performance Measure 07:.....	87
Performance Measure 08:.....	90
Performance Measure 09:.....	93
Performance Measure 10:.....	96
Performance Measure 11:.....	100
Performance Measure 12:.....	103
Performance Measure 13:.....	107
Performance Measure 14:.....	109
Performance Measure 15:.....	112
Performance Measure 16:.....	115
Performance Measure 17:.....	119
Performance Measure 18:.....	122
D. State Performance Measures.....	125
State Performance Measure 1:	125
State Performance Measure 2:	129
State Performance Measure 3:	132
State Performance Measure 4:	135
State Performance Measure 5:	138
State Performance Measure 6:	142
State Performance Measure 7:	145
E. Health Status Indicators	148
Health Status Indicators 01A:.....	148
Health Status Indicators 01B:.....	149

Health Status Indicators 03A:.....	150
Health Status Indicators 03B:.....	150
F. Other Program Activities.....	151
G. Technical Assistance	153
V. Budget Narrative	156
Form 3, State MCH Funding Profile	156
Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds.....	156
Form 5, State Title V Program Budget and Expenditures by Types of Services (II).....	157
A. Expenditures.....	157
B. Budget	159
VI. Reporting Forms-General Information	162
VII. Performance and Outcome Measure Detail Sheets	162
VIII. Glossary	162
IX. Technical Note	162
X. Appendices and State Supporting documents.....	162
A. Needs Assessment.....	162
B. All Reporting Forms.....	162
C. Organizational Charts and All Other State Supporting Documents	162
D. Annual Report Data.....	162

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//

/2014/ DSHS continued to seek out public input on issues regarding maternal and child health populations. This input is considered very important to MCH/CSHCN program operations. DSHS programs maintained regular communication with stakeholders, both internal and external to the agency, through a variety of advisory committees, workgroups, and other groups that address needs and issues pertinent to maternal and child health populations. Programs maintained various distribution lists to share information and seek feedback throughout the year that is relevant to their programs.

Additionally, programs had frequent communication with contractors, professional organizations, advocates, and family members through various teleconferences and webinars. The Office of Title V and Family Health, along with the CSHCN Services Program and other DSHS programs, maintain unique e-mail accounts where stakeholder feedback or questions can be submitted throughout the year. DSHS contractors are encouraged to submit feedback either via e-mail or during conference calls on any and all topics related to maternal and child health.

DSHS posted a draft of the Texas Title V Activity Plan for FY13 and Annual Report for FY11 in July 2012. Contractors and other stakeholders were notified of the posting. Minimal comments were received. The final versions of these documents were posted to the DSHS website following the annual Block Grant Review meeting in August 2012. Notices were distributed to various DSHS programs that the final documents were posted to the website. //2014//

II. Needs Assessment

In application year 2014, 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. <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//

/2014/ DSHS staff continued to perform a variety of needs assessment activities related to maternal and child health populations throughout fiscal year 2013.

PRAMS -- The annual Pregnancy Risk Assessment Monitoring System (PRAMS) survey was completed by approximately 1,800 women. PRAMS data for Texas are now available for the years 2002 through 2011. Additionally, the 2010 PRAMS data book is also available via the DSHS website and can be accessed at <http://www.dshs.state.tx.us/mch/#PRAMS2>.

***WIC / Breastfeeding Survey -- WIC surveyed clients to measure attitudes, beliefs, knowledge, and practices pertaining to breastfeeding to gain insight into barriers in order to improve programmatic initiatives. For 2012, more than 3,200 clients answered the survey at over 100 WIC clinic locations.
<http://www.dshs.state.tx.us/wichd/nut/nesurveyresults.shtm>.***

DSHS Contractors -- Throughout the fiscal year, Title V Fee-for-Service contractors as well as the CSHCN Services Program (CSHCN SP) community based contractors participated in agency conference calls to share pertinent information and provide feedback to DSHS staff. Contractors are encouraged to make suggestions and share concerns or issues to staff during these conference calls, via e-mail or other written correspondence, or during on-site visits. CSHCN SP staff maintained stakeholder meeting records to better understand the needs of the families they serve and utilize this data in future programmatic initiatives. The CSHCN SP also surveyed their health care benefits clients for program satisfaction. Data analysis is still pending completion for this survey. //2014//

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//

/2014/ In 2012, for the first time in several years, data from the Bureau of Transportation Statistics at the US Department of Transportation indicated there was a 2% increase in the number of vehicles (33,052,693) and a 4% increase in the number of people (72,898,341) who entered the U.S. at Texas border checkpoints. //2014//

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//

/2014/ The Texas State Data Center projected that Texas' population will exceed 27 million during the year 2015 and by 2040 will reach a population of 45 million people, if the migration rate remains the same as it was from 2000 to 2010. Even if migration stagnates to zero, the population of Texas is expected to be over 26 million by 2015 and over 30 million by 2040. (Source: Texas State Data Center, 2013.) //2014//

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//

/2014/ The Texas State Data Center estimated that approximately 10.4% (2.6 to 2.7 million depending on the migration rate) of Texas residents were living along the Texas-Mexico border. Among the border and non-border Texas residents, approximately 56% and 51% were less than 35 years of age, respectively. Similarly, among the Texas residents living in urban counties (87%), 52% were less than 35 years age compared to 46% of the Texas residents in rural counties. //2014//

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//

/2014/ The Texas State Data Center estimated total female population in Texas to be 50.4% of overall population and 51% of the population in border areas. Women of childbearing ages 15-44 years account for 41.7% of the total female population. //2014//

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//

/2014/ Per The Texas State Data Center, the Texas population is estimated to be comprised of approximately 11.5 million (44.7%) Non-Hispanic Whites, 9.8 million (38.2%) Hispanics and 3.0 million (11.5%) Blacks. In 2010, 7.7% of Texans were less than five years of age and 28.4% were less than 18 years of age. //2014//

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//

/2014/ As of December 2011, there were 137,621 children in Texas younger than 18 years of age that received SSI. Texas continues to have the highest number of children receiving SSI. //2014//

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.

/2014/ Texas has a higher population density than the national average (87.4 per square mile) with 96.3 people per square mile. Harris County, the most populous county, has a density of 2,402 people per square mile, whereas Loving County, the least populous county, only has 1 person per 10 square miles. Eighty-five of Texas' 254 counties have populations less than 10,000, whereas five have populations exceeding one million. //2014//

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//

/2014/ According to the American Community Survey in 2011, it is estimated that 18.5% of individuals and 14.4% of families lived under the federal poverty level in Texas. //2014//

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//

/2014/ The 2011 American Community Survey estimated that approximately 22.1% of child-bearing aged women age (18-44) had incomes below the poverty level. Among children younger than 18 years of age, 21.5% were living in households with incomes below poverty level. This percentage places Texas above the 18.6% national average. For children younger than five years, 21.1% were living in households with incomes below the poverty level, also above the national average of 19.4%. //2014//

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//

/2014/ Results from the 2011 American Community Survey indicated that the median income of households in Texas was \$49,392 and per capita income was \$24,682. County

level data is not yet available. //2014//

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//

/2014/ As of March 2013, the Bureau of Labor Statistics reported that Texas was tied at 18th with Massachusetts for the lowest state-level unemployment rate at 6.4%. Between March 2012 and February 2013, Sabine and Starr counties had the highest unemployment rate in Texas, exceeding 14%. There were 21 counties with unemployment rates below 4%. //2014//

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//

/2014/ The 2011 provisional Texas Birth and Mortality data indicated 8.3% of infant deaths were SIDS related, a decrease of 12.6% since 2009 (9.5%). In 2011, the rate of SIDS among Black infants (1.1 per 1,000 births) was still almost twice that of White infants (.6 per 1,000 births). Hispanic infants continue to have the lowest rates of SIDS (.29 per 1,000 births). //2014//

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//

/2014/ The maternal mortality rate in Texas, using the most inclusive definition, was 30.7 per 100,000 live births in 2011. //2014//

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.

/2014/ In 2011, the American Community Survey estimated that 33.8% of women of childbearing age (18-44) had no health care coverage. //2014//

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//

/2014/ In 2011, the DSHS Center for Health Statistics reported that 9.5% of the total charges billed for care in acute care hospitals was uncompensated. Uncompensated care charges (bad debt and charity) increased from \$5.5 billion in 2001 to \$18.1 billion in 2011. Public, non-profit and for-profit hospitals provided 33.7%, 42.3% and 24% of the uncompensated care, respectively. Charity care accounted for 56.9% (\$10.3 billion) of the total uncompensated care. //2014//

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.

/2014/ Results from the 2011 American Community Survey indicated that approximately

23% of all Texans were uninsured in 2011. Among children younger than 18 years, 13.2% did not have any health coverage. Nationally, 7.5% of children younger than 18 were uninsured. //2014//

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//

/2014/ As of January 2013, 134 counties were recognized as having too few primary care physicians. //2014//

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//

/2014/ Approximately, 37.7% of Texas the 254 counties were recognized as having too few dentists. //2014//

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//

/2014/ As of January 2013, 202 (79.5%) of the 254 counties were recognized as having too few mental health providers. //2014//

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//

/2014/ The Healthy Texas Babies initiative continued through fiscal year 2012 with 11 local community coalitions implementing evidenced-based interventions to reduce the incidence of preterm birth and infant mortality. Based on formative research conducted, DSHS began planning a public awareness and education campaign focusing on preconception and interconception planning.

The Expert Panel was continued throughout FY12 with two in-person meetings to facilitate communication and consultation on activities related to the Healthy Texas Babies initiative. Plans were drafted to develop a sustainable infrastructure for a statewide collaborative effort for the initiative.

Funding to continue the initiative was authorized as part of the 83rd Legislative Session General Appropriations Act for DSHS. //2014//

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.

***/2014/ The plan for state fiscal years 2013-2017 may be found at:
<http://www.hhs.state.tx.us/StrategicPlans/SP-2013-2017/SP-13-17.shtml>. //2014//***

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//

/2014/ The 83rd Legislature, Regular Session, met from January - May, 2013. The First Called Session met in May - June, 2013. A Second Called Session met in July 2013 and a Third Called Session met in August 2013. The attached table summarizes key maternal and child health legislation passed in the Regular Session. //2014//

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//

/2014/ The number of certified community health workers (CHWs) continued to increase in calendar year 2012. As of December 31, 2012, there were over 2,000 certified CHWs in Texas. DSHS, in conjunction with HHSC, released the Texas Community Health Worker Study report which included recommendations related to maximizing employment of and access to promotores and CHWs to provide publicly and privately funded health care services and identifying methods of funding and reimbursement. CHWs continued to organize regional or local networks or associations across the state. DSHS continued to explore mechanisms to incorporate community health worker models in the delivery of services. Four CHW instructors are currently certified as Master Trainers by the University of Illinois to provide the Diabetes Empowerment Education Program (DEEP) curriculum and are working with CHW training programs to provide education to CHWs. //2014//

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//

/2014/ The 83rd Legislature increased DARS' funding appropriations for ECI services for fiscal years 2014 and 2015. The additional funds will allow for increased caseload growth and an increase in the average monthly service hours per child. //2014//

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//

/2014/ The CSHCN SP provided health care benefits to 2,019 clients in FY12. A total of 155 clients were removed from the waiting list effective September 1, 2012. An additional 116 clients were removed from the waiting list effective March 15, 2013. //2014//

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.

/2014/ TxP2P partnered with Texas Children's Health Plan as a subcontractor to implement transition activities of the HRSA MCHB State Implementation Grant for Integrated Community Systems for CYSHCN called the Statewide Association for Regional Medical Home AdvanCement (STARMHAC). TxP2P established and began conducting "Pathways to Adulthood" workshops statewide for families of CYSHCN to encourage parent-to-parent support networks and in-depth planning for transition-age youth. //2014//

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.

//2014/ CSHCN SP supported the Texas Children's Health Plan (TCHP) application and promoted collaboration among stakeholders for the STARMHAC grant to build a statewide infrastructure for the six key Title V performance measures relating to CYSHCN. The initiative includes development of a medical home learning collaborative. CSHCN SP continues monitoring activities and developments. //2014//

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.

An attachment is included in this section. IIIB - Agency Capacity

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//

/2014/ Please refer to Attachment III. C. Organizational Structure for agency organizational charts effective June 2013. //2014//

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 Mabelle 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//

/2014/ Dr. Linda Gaul was selected as the State Epidemiologist in April 2013. She previously served as interim State Epidemiologist since September 2012. Dr. Gaul is a graduate of the University of Wisconsin at Madison where she received her M.S. and Ph.D. degrees in Plant Physiology, in addition to being a graduate of the University of Texas at Houston where she received a Master's of Public Health degree. Prior to her work at DSHS, Dr. Gaul served as an Assistant Professor at Texas State University System, and a Biology

Senior Lecturer at the University of Texas at Austin. //2014//

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//

/2014/ Manda Hall, MD, joined DSHS as the Title V CSHCN Director in October 2012. Dr. Hall is board certified in Pediatrics, Internal Medicine, and Allergy and Immunology. Previously, she worked at DARS Division for Disability Determination Services as a state agency medical consultant. She also has experience in private practice. Currently, Dr. Hall is a fellow in the Maternal and Child Health Public Health Leadership Institute. //2014//

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//

/2014/ Attachment III. D. Other MCH Capacity has been updated as of June 2013. Compared with FY12, there was a net decrease of more than 30 FTEs funded fully or in part with Title V Block Grant funding. While fewer FTEs may be funded by the Block Grant, DSHS continues to ensure that critical positions related to maternal and child health remain funded to support state services. //2014//

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.

/2014/ Dr. Becker resigned from her position with DSHS to accept a new role as the Medicaid/CHIP Mental Health Director for HHSC. She will remain involved in cross agency efforts to improve behavioral health integration. //2014//

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//

/2014/ In FY12, the Division for Prevention and Preparedness was reorganized to shift responsibilities for disaster preparedness and response to the Division for Regional and Local Health Services. The newly named Division for Disease Control and Prevention is responsible for infection and chronic disease control and prevention as well as the state laboratory services.

Dr. Suarez retired from DSHS on January 31, 2013. Janna Zumbrun, MSSW, was named Assistant Commissioner for the Division for Disease Control and Prevention on August 1, 2013. She has served DSHS in various capacities as the Field Operations Manager in the Bureau of HIV/STD Prevention, Health Promotion Unit Manager, TB/HIV/STD Unit Manager, and most recently as Director of the Infectious Disease Prevention Section and Interim Assistant Commissioner.

David Gruber has served as the new Assistant Commissioner for the Division for Regional and Local Health Services (RLHS) since March 2013. The RLHS Division is responsible for overseeing the eight Health Service Regions, the Community Preparedness Section, and coordinating state and local public health efforts. Mr. Gruber previously served as the Special Assistant to the Director of the New Jersey Office of Homeland Security and Preparedness as well as Senior Assistant Commissioner in the New Jersey Department of Health. //2014//

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//

/2014/ Bonita Childress, RN, assumed the role of interim director of OPDS effective October 2012. //2014//

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.

/2014/ Ms. Melton-Kissel has announced her retirement from DSHS effective August 31, 2013. //2014//

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.

/2014/ Dr. Altenhoff accepted a new position with the Health and Human Services Commission Office of Inspector General as their Dental Director / Chief Dental Officer. Her last day with DSHS was June 21, 2013. Dr. Vy Nguyen, DDS, will serve as the dental team lead until a new State Dental Director is hired. //2014//

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//

***/2014/ Dr. Manda Hall has served as the Title V CSHCN Director since October 2012.
//2014//***

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.

//2014/ Mike Montgomery retired from DSHS effective April 30, 2013. Evelyn Delgado, Assistant Commissioner for FCHS, currently serves as Interim Director of the Nutrition Services Section. //2014//

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 CSHCN 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, CSHCN, 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 CSHCN 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//

/2014/ The ESC and Task Force HHSC support staff received and used the formative assessment to write a proposal around developing, building, and testing the website over the course of about 18 months. Advance planning documents for Balancing Incentives Program (BIP) funding have been completed and submitted for review by the Centers for Medicare and Medicaid Services (CMS), hoping for approval by September 1, 2013. The ESC appointed a work group of agency representatives and family members to write the implementation plan for Crisis Prevention and Intervention. Its members include the FCHS Assistant Commissioner and one other FCHS staff member. The work group identified four strategies with twelve tactics needing implementation. "Supporting parents and families" and "strengthening local linkages and coordination" were the tactics with the highest priority. The work group plans to complete recommendations for these tactics by August 31, 2013, and will continue working on recommendations for the remaining tactics in the coming year. //2014//

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//

/2014/ The Texas System of Care led by HHSC, DSHS, and the Texas Institute for Excellence in Mental Health in collaboration with child-serving state agencies, family and

youth advocacy organizations and other stakeholders developed and released its strategic plan to expand systems of care for youth with serious mental health challenges. SAMSHA awarded Texas System of Care a four-year grant to implement the plan. The 83rd Legislature amended existing legislation, formerly referred to as the Texas Integrated Funding Initiative (TIFI) through Senate Bill 421, to create the Texas System of Care Consortium to oversee implementation activities, evaluate outcomes, and make recommendations to improve children's mental health services across systems. //2014//

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.

/2014/ The Office of Program Coordination for Children and Youth, the Office of Early Childhood Coordination, and the Office of Acquired Brain Injury were consolidated in to the new Office of Health Coordination and Consumer Services effective November 15, 2012. //2014//

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

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

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	24.1	25.6	20.3	18.9	17.6
Numerator	4642	4986	3921	3663	3422
Denominator	1927981	1951170	1928473	1938308	1945480
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012

The indicator is calculated using a linear trend from 2006 to 2011.

Denominator data are provided by the Office of the State Demographer.

Notes - 2011

The data are based on hospitalizations. Therefore, one person may account for multiple hospitalizations. The reported data may underestimate the true rate of hospitalizations for asthma because some Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the Texas Health Care Information Collection (THCIC).

Denominator data are provided by the Office of the State Demographer.

Notes - 2010

Data Source: Texas Hospital Inpatient Discharge 2010 Public Use Data File.
This indicator has been adjusted for final data.

The data are based on hospitalizations. Therefore, one person may account for multiple hospitalizations. The reported data may underestimate the true rate of hospitalizations for asthma because some Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the THCIC. Denominator data are provided by the Office of the State Demographer.

Narrative:

The Healthy People 2020 target for reducing the rate of children hospitalized for asthma for children less than five years of age is 18.9 hospitalizations per 10,000. Provisional data for FY12 indicates that Texas has met this objective continuing a decline in hospitalizations that began in 2009.

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

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	59.4	60.2	63.1	65.3	65.8
Numerator	240687	241804	243537	246130	250471
Denominator	405242	401599	385746	377124	380495
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012

The 2012 birth file from Center for Health Statistics is preliminary and subject to change.

Notes - 2011

2011 data are based on a provisional 2011 birth file. The 2011 birth file should be finalized in August 2013. These numbers are subject to change. If unknowns are excluded, the denominator changes to 376,881 and the percentage remains 65.3%.

Notes - 2010

May 2012: Data for 2010 is finalized. If unknowns are excluded, the denominator changes to 378,772, making the percentage 64.3.

In 2005, Texas implemented the US Certificate of Live Birth, 2003. This change had a significant impact on measures of prenatal care utilization. Numerator estimates are based on a linear trend

of data from 2005-2008 and denominator estimates are based on a linear trend of births from 1996-2008.

Narrative:

Provisional data indicate that the percent of women (15 through 44) with a live birth whose observed to expected prenatal visits greater than or equal to 80% on the Kotelchuck Index have continued a gradual increase over the last five years. DSHS continues to promote early access to prenatal care through existing contracts with medical providers and through population-based educational efforts through the Health Texas Babies initiative.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2012	payment source from birth certificate	8.7	7.8	8.2

Narrative:

The provisional data for 2012 indicate improvements in all of the variables in HSCI 05 compared to 2011, however there remain disparities between the Medicaid and non-Medicaid populations. The department will continue to focus efforts on addressing all birth outcomes and build upon partnerships with the Medicaid agency to address these issues.

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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	470	524	554	571	579
Denominator	470	524	554	571	579
Data Source	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
	2013	2014	2015	2016	2017
Annual Performance Objective	100	100	100	100	100

Notes - 2012

Data are taken from Form 6.

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.

a. Last Year's Accomplishments

Activity 1: A total of 378,285 initial newborn screening specimens submitted identified 2,116 (0.56%) specimens as unsatisfactory. DSHS initiated 14,713 contacts on unsatisfactory specimens; however, this number represents multiple contacts for one specimen and/or multiple contacts to one submitter. Education materials distributed included 363 Weight Conversion Charts, 346 Specimen Collection Guides, 129 Spot Check Guides, 19 sets of ACT / FACT sheets, 157 Newborn Screening Submitter Packets, 34 CD Slide Presentations and 156 Neonatal Screening brochures.

Activity 2: Education items distributed included 106,121 Newborn Screening Program (NBS) Brochures, 695 NBS posters, and 5,117 bookmarks. In addition, DSHS mailed 4,956 Sickle Cell Trait Letters and 4,956 information brochures. A total of 269,876 web-based encounters occurred on the NBS website. More than 1,200 NBS providers completed online education modules. There were 816 new web based system users added for NBS online services.

Activity 3: DSHS maintained the online resource, Information for Parents of Newborns, on the MCH website and printed versions in Spanish and English formats. The department distributed 137,148 English versions and 46,447 Spanish versions by mail. Stakeholders submitted comments and questions to the dedicated infoforparents@dshs.state.tx.us mailbox.

Activity 4: DSHS analyzed data from 2010 and 2011 on all specimens submitted for newborn screening to calculate the pre-analytical performance measures. The results were presented at the Newborn Screening Advisory Committee meeting on November 2, 2012. Submitters started accessing the new report card via secure remote access in Spring 2013.

Performance Assessment: Effective outreach to providers and families through increased distribution of education materials distributed in FY12 and provision of more technical assistance continued to ensure that identified newborns received needed follow-up and treatment. NBS continued to meet the annual objective of 100% follow up and case management of identified presumptive positives.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures.				X
2. Activity 2: Educate parents and health professionals about newborn screening benefit, state requirements, and importance of follow-up to positive tests.			X	
3. Activity 3: Promote prenatal distribution of Information for Parents of Newborns to provide parents with info about SIDS prevention, immunizations, shaken baby syndrome prevention, post partum depression, newborn screening, and other resources.			X	
4. Activity 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 1,634 (.84%) unsatisfactory initial newborn screening specimens submitted out of 193,032, resulting in 11,000 contacts with submitters. Education materials distributed included 53 Weight Conversion Charts, 167 Specimen Collection Guides, 44 Spot Check Guides, 68 Newborn Screening Submitter Packets, 20 CD Slide Presentations and 33 Neonatal Screening brochures.

Activity 2: Education materials distributed included 49,844 Newborn Screening Program (NBS) Brochures, 51 NBS posters, and 1,665 bookmarks. Additionally, DSHS mailed 2,555 Sickle Cell Trait Letters and 2,555 information brochures. There were 171,028 web-based encounters, of which 288 were NBS providers who accessed NBS online education modules, and 701 new web-based system users were added for NBS online services.

Activity 3: The resource, Information for Parents of Newborns, remains available both electronically for download and in print, for English and Spanish speakers. The print versions can be ordered via the DSHS Forms and Literature Catalog. To date, DSHS distributed 85,198 print booklets in English and 24,201 in Spanish. Comments and questions continue to be received via the dedicated email account.

Activity 4: Data regarding newborn screening unsatisfactory specimen rates, including specimens deemed satisfactory for some, but not all disorders, was monitored and reported monthly to the DSHS Laboratory's Quality Assurance and Management Team.

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 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; track dissemination of materials.

Activity 2: Educate parents, including expectant and postpartum parents, and health professionals about importance and benefit of newborn screening/follow-up to positive tests, and state requirements by distributing newborn screening brochures to health care providers, providing Information for Parents of Newborn Children pamphlets to all expectant and postpartum parents through health care providers and facilities, posting newborn screening information to the NBS Program website, and responding to inquiries about newborn screening via a dedicated email address.

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): Average statewide time from specimen collection to receipt in the DSHS Laboratory; percentage of first screen specimens collected at 24-48 hours of life.

Monitoring: Statistical reports from 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.

Total Births by Occurrence:	389901					
Reporting Year:	2012					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	No.
Phenylketonuria (Classical)	379341	97.3	54	10	10	100.0
Congenital Hypothyroidism (Classical)	379341	97.3	7345	214	214	100.0
Galactosemia (Classical)	379341	97.3	176	3	3	100.0
Sickle Cell Disease	379341	97.3	231	168	168	100.0
Biotinidase Deficiency	379341	97.3	206	30	30	100.0
Cystic Fibrosis	379341	97.3	421	68	68	100.0
Homocystinuria	379341	97.3	153	3	3	100.0
Maple Syrup Urine Disease	379341	97.3	97	3	3	100.0
beta-ketothiolase deficiency	379341	97.3	0	0	0	
Tyrosinemia Type I	379341	97.3	1	1	1	100.0
Very Long-Chain Acyl-CoA	379341	97.3	123	4	4	100.0

Dehydrogenase Deficiency						
Argininosuccinic Acidemia	379341	97.3	99	2	2	100.0
Citrullinemia	379341	97.3	99	1	1	100.0
Isovaleric Acidemia	379341	97.3	511	2	2	100.0
Propionic Acidemia	379341	97.3	510	2	2	100.0
Carnitine Uptake Defect	379341	97.3	706	4	4	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	379341	97.3	199	17	17	100.0
Methylmalonic acidemia (Cbl A,B)	379341	97.3	510	7	7	100.0
Multiple Carboxylase Deficiency	379341	97.3	0	0	0	
Trifunctional Protein Deficiency	379341	97.3	0	0	0	
Glutaric Acidemia Type I	379341	97.3	243	2	2	100.0
Hydroxymethylglutaric Aciduria	379341	97.3	0	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	379341	97.3	214	14	14	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	379341	97.3	34	1	1	100.0
Methylmalonic Acidemia (Mutase Deficiency)	379341	97.3	510	1	1	100.0
Congenital Adrenal Hyperplasia (Classical)	379341	97.3	4432	21	21	100.0
Severe Combined Immunodeficiency	30424	7.8	390	1	1	100.0
Hearing Screening	2577316		40266	0	11651	
Vision Screening	2651490		219310	0	98249	
Spinal Screening	751352		23700	0	4258	

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	58	58.1	58.2	58.3	72
Annual Indicator	57.9	70.3	70.3	70.3	70.3
Numerator	450786	639197	639197	639197	639197
Denominator	778339	908622	908622	908662	908662
Data Source	National	National	National	National	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
	2013	2014	2015	2016	2017
Annual Performance Objective	72	74	74	75	75

Notes - 2012

For 2011-2014, indicator data come 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 mistakes.

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.

a. Last Year's Accomplishments

Activity 1: CSHCN Services Program (CSHCN SP) contractors and central office and regional staff attended numerous stakeholder meetings that included participation by youth and family members. Priority concerns included difficulty navigating complex systems, transitioning to adulthood, finding health insurance and pediatric specialists, accessing medical transportation, and scarce respite resources. Staff participated in a round table with families to discuss needs and challenges at the Texas Parent to Parent (TxP2P) annual conference.

A statewide formative assessment was conducted on behalf of the Task Force for Children with

Special Needs to determine families' needs for web-based information. Focus groups participants included English and Spanish-speaking parents, Task Force members, community-based providers, and others. A total of 131 parents participated at 10 different locations.

Family members of the Children's Policy Council met with HHSC and DADS leadership to share personal stories and present recommendations on statewide initiatives underway, including Medicaid expansion impacting CYSHCN and their families. CSHCN SP staff provided input and support for this effort.

Staff worked closely with family members on the Consumer Direction Workgroup to make recommendations to DADS in advance of the expansion of an electronic timekeeping system for personal attendants. Program and policy changes were made as a result of stakeholder input.

Community-based contractors continued close collaborations in their communities promoting the interests of CYSHCN families. They sponsored workshops and conferences, participated in health fairs, published newsletters, and assisted families in accessing transportation, health care and basic needs services to help families connect and partner with service providers and decision makers.

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. Another contractor, Families CAN, held its first Transition Family Educational Event with participation of over 100 families.

The AMCHP Family Scholar and TxP2P staff member partnered with CSHCN SP staff to present, "The Power of One: You!" at the 2012 TxP2P annual conference. Attendees set goals and identified action steps to engage more closely with decision makers.

The CSHCN SP Family Newsletter included articles on Obesity, Tips for Choosing a Doctor, and Emergency Room Visits.

Activity 2: CSHCN SP staff gauged family satisfaction with contracted services and obtained input for improvement utilizing a survey with standardized core questions. A total of 1,724 family surveys were evaluated and 1,714 (99.4%) respondents reported overall satisfaction with contractor services. Additionally, 1,707 (99.1%) were satisfied with access to services and information, 1,712 (99.3%) were satisfied with customer service, and 1,699 (98.7%) were satisfied with family involvement in planning, delivery, and decision making.

Activity 3: Results from 386 respondents to an FY11 survey of families of CYSHCN were analyzed in FY12 and compared to the FY10 Title V Needs Assessment. Key findings included increases in parents' ability to ask their child's doctor questions concerning care, the number of children seeing the same doctor for regular care, and parents feeling they can partner with doctors to make decisions. Fewer parents reported needing help finding equipment and family support services.

CSHCN SP's Quality Management Team developed a client survey for distribution in FY13. Throughout FY12, staff circulated various statewide surveys to regional staff and contractors to encourage participation and input from families of CYSHCN.

Performance Assessment: Families partnering with providers and being satisfied with their services remained a priority for the CSHCN SP. Contractor client/family surveys consistently reported high levels of overall satisfaction with services. However, stakeholder priority concerns continue to be identified and impact program planning and development. Continued efforts to engage families and encourage participation in decision making should continue to support increased levels of family satisfaction.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Activity 1: CSHCN SP staff assisted in planning activities for TxP2P's annual conference and submitted speaker proposals which were accepted. TxP2P distributed a Family Voices national survey assessing whether families are receiving family-centered care to its statewide network.

CSHCN SP staff distributed information to regional staff and contractors encouraging family engagement in HHSC's Medical Transportation Program (MTP) stakeholder forums to collect input on proposed restructuring changes.

Family input during interagency workgroups included concerns about missed opportunities to support children with mental illness at an early age, Medicaid expansion activities, and the ongoing need for family input at all levels. In partnership with families, CSHCN SP staff and contractors continued active involvement in numerous workgroups.

Family members of the Children's Policy Council educated legislators and staff on priority needs of CYSHCN and their families.

Activity 2: To date, 609 contractors' family surveys were evaluated. All 609 (100%) reported overall satisfaction with contractor services, 606 (99.5%) were satisfied with access to services and information, 608 (99.8%) were satisfied with customer service, and 607 (99.6%) were satisfied with family involvement in planning, delivery, and decision making.

Activity 3: CSHCN SP distributed and started analyzing responses to its survey of health care benefits clients assessing the utilization of services and client satisfaction.

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): Documentation of staff and contractor participation in key CYSHCN family stakeholder groups; 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; documentation of priority concerns/suggestions relevant to CYSHCN.

Monitoring: Review information from Stakeholder Meeting Records, regional meeting/events, contractor quarterly reports, conference call meeting minutes, 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 contractor services; recommendations/input to contractors from CYSHCN families and contractor response to this feedback.

Monitoring: Review contractor quarterly reports and Quality Assurance (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): Family satisfaction assessment activities implemented; data analysis and recommendations made/actions taken.

Monitoring: Satisfaction assessment efforts; progress, barriers, and results from Stakeholder Meeting Records, focus groups, listening sessions, surveys, and other activities.

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	2008	2009	2010	2011	2012
Annual Performance Objective	46.4	46.5	46.6	46.7	42
Annual Indicator	46.3	40.1	40.1	40.1	40.1
Numerator	351768	355285	355285	355285	355285
Denominator	759974	886995	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
	2013	2014	2015	2016	2017
Annual Performance Objective	43	44	45	46	46

Notes - 2012

For 2011-2014, indicator data come 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 mistakes.

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.

a. Last Year's Accomplishments

Activity 1: The Medical Home Workgroup (MHWG) met quarterly with active discussion of initiatives and updates. Topics included the Blue Cross Blue Shield Texas Medical Home Pilot Project, Healthy Texas Babies (HTB), Raising Texas, LEAH conference, Project Access Learning Collaborative for children with epilepsy, Emergency Medical Services for Children, parent-led Hali Project which trains 'Parent Partners' to coordinate family-centered care in pediatric practices, and the Health Quilt Project funded to pilot a prototype health information exchange for the City of Houston and Greater Harris County area.

The THSteps Medical Home module, which includes information on the National Committee for Quality Assurance (NCQA) Medical Home Recognition standards, was completed by 534 health care professionals. There were 3,639 unique visits to the medical home page.

Activity 2: CSHCN SP contractors and regional staff assisted 2,250 families receiving case management in finding a medical home. A total of 3,190 (84.1%) CYSHCN clients that received case management had a primary care provider (PCP). Of the CYSHCN who had a PCP, 3,144 (98.4%) had seen that PCP within the past 12 months.

CSHCN SP staff visited with contractors statewide and provided technical assistance on medical home to assess understanding and enhance promotion of medical home principles. Any Baby Can of Austin continued its partnership with the Children's Health Express mobile clinic which serves as a medical home to CYSHCN.

Contractors assisted families in finding PCPs for their CYSHCN and several contractors provided medical home supports to families in clinical settings. South Texas Assessment and Referral Services continued complex assessments and served as a medical home for CYSHCN. Scott & White Memorial Hospital coordinated care for children in various specialty clinics to help families consolidate multiple medical appointments into one visit. The University of Texas Health Science Centers in San Antonio and Houston provided comprehensive medical home supports to children with serious, complex conditions that had no other available services in their communities.

Activity 3: CSHCN SP staff participated in HTB intra-agency workgroup activities to highlight the importance of a medical home for infants. Staff delivered a presentation for DSHS and HHSC employees and participated in a round table discussion featuring medical home at the HTB Expert Panel meeting.

HRSA awarded the Systems of Services for Children and Youth with Special Health Care Needs grant to the Texas Children's Health Plan (TCHP). CSHCN SP staff assisted with the application process and facilitated collaboration between stakeholders. TCHP formed the Statewide Association for Regional Medical Home AdvanCement (STARMHAC) to develop a medical home learning collaborative and recruit regional teams to use continuous quality improvement techniques to increase access to medical homes. Staff participated in the Project Access Epilepsy Learning Collaborative's monthly conference calls and attended their annual conference to partner with stakeholders to improve access to care for children and youth with epilepsy through the medical home.

Performance Assessment: CSHCN SP promoted awareness and access to medical home across the state. The MHWG and major Texas initiatives such as STARMHAC and HTB increased awareness of the medical home concept for families, physicians, third party payors, state agency personnel, and others. CSHCN SP contractors continued to assist families in identifying PCP's, finding a medical home and providing medical home supports.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Provide leadership to and collaborate with the Medical Home Workgroup & others to increase awareness, knowledge, implementation, and access to quality medical home practice and integrated dental and mental/behavioral health services.			X	X
2. Activity 2: CSHCN SP regional staff and contractors help CYSHCN access medical homes and integrated dental and mental/behavioral health services.		X		X
3. 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.		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The MHWG met quarterly and reviewed ongoing initiatives and updates to the strategic plan. Topics included the HRSA funded Texas Children's Health Plan's STARMHAC project, Rhode Island Patient-Centered Medical Home Initiative, Medical Home for High-Risk Patients, and a National Academy for State Health Policy presentation, "Supporting Healthy Child Development through Medical Homes." Dr. Sue Bornstein, a member of the MHWG, announced the upcoming Texas Medical Health Home Initiative's, "Texas Health/Medical Home Summit," the first Texas conference focused on expanding access to a medical home. Staff assisted in recruiting family participants.

Activity 2: Contractors and regional staff assisted 1,134 families in finding a medical home. To date, 131 contractors and other health care professionals completed the THSteps' Introduction to the Medical Home training module. Efforts began to update the module.

Contractors and regional staff continued educating families about medical home practices and provided resource information.

Activity 3: CSHCN SP staff continued collaboration with STARMHAC and participated in project conference calls to encourage involvement of community-based agencies serving CYSHCN and families. CSHCN SP collaborated with the National Center for Project Access Epilepsy Foundation to provide an upcoming training event where staff will present on medical home and transition.

An attachment is included in this section. IVC_NPM03_Current Activities

c. Plan for the Coming Year

Activity 1: Lead the Medical Home Workgroup (MHWG) to increase knowledge, implementation of and access to quality medical home practices and integrated dental and mental/behavioral health services.

Output Measure(s): Input/guidance received on medical home practices from MHWG members and others; updates to the MHWG Strategic Plan; promote medical home outcome measures for CYSHCN across state programs; publications authored, presentations given, and resource materials exchanged.

Monitoring: Review MHWG Strategic Plan; meeting minutes; publications, presentations; resource materials.

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 who have a primary care physician (PCP) and who have seen that PCP in the past 12 months; number and percent of CYSHCN identified as needing a medical home and assisted in finding a medical home by regional staff and contractors; activities to promote access to and integration of medical home, dental, and mental/behavioral health services.

Monitoring: Review regional activity and contractor quarterly reports; contractor conference call meeting minutes; site visit reports.

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 implementation and progress of medical home initiatives; identification of initiatives focused on integration of dental and mental health services; publications authored for/presentations given to CYSHCN families, providers and others;

utilization of and updates to the CSHCN SP Medical Home webpage; utilization of the THSteps Introduction to Medical Home training module.

Monitoring: Review of medical home projects and other initiatives; Stakeholder Meeting Records; utilization and updates to the CSHCN SP Medical Home webpage; THSteps training module data; relevant publications, presentations, and staff activity documentation.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	58.3	58.4	58.5	58.6	58.7
Annual Indicator	58.2	58.0	58.0	58.0	58.0
Numerator	462528	520600	520600	520600	520600
Denominator	795137	898296	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
	2013	2014	2015	2016	2017
Annual Performance Objective	58.8	58.9	58.9	58.9	58.9

Notes - 2012

For 2011-2014, indicator data come 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 mistakes.

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.

a. Last Year's Accomplishments

Activity 1: Texas received approval from the Centers for Medicare and Medicaid Services (CMS) for a waiver allowing for statewide Medicaid managed care expansion while preserving hospital funding, providing incentive payments for health care improvements and directing more funding to hospitals that serve large numbers of uninsured patients. Services included dental care for children and young adults age 20 or younger in Medicaid or CHIP and pharmacy benefits.

Staff provided input to the Children's Policy Council's efforts to identify key issues for CYSHCN in accessing health and dental services under managed care which family members, including TxP2P's Executive Director, presented to HHSC and DADS leadership.

Staff advocated on behalf of families accessing the Medical Transportation Program (MTP) and helped ensure clients would not lose benefits. Staff made system changes allowing for the enrollment of FQHCs and Rural Health Clinics and identified a way to improve the Online Provider Look up making it easier for families to find providers. Staff worked with Medicaid/CHIP and others redesigning the provider enrollment system to centralize and streamline the process. A new expedited enrollment application was implemented to allow active Medicaid providers to enroll in the CSHCN SP with simple agreements. GeoAccess maps are now utilized to help identify provider shortages in specific areas.

Regional staff and contractors helped families access transportation to medical appointments and assisted families with CHIP, Medicaid, and CSHCN SP applications to access benefits and prevent coverage lapses.

Any Baby Can of Austin trained case managers to utilize the 'Medicaider', an online financial screening tool to help families complete applications for Medicaid, CHIP, and local county health services. They also continued hosting bi-monthly mobile health clinics to serve CYSHCN. Coalition of Health Services assisted CYSHCN without insurance in accessing extensive dental services at no cost to families. South Texas Assessment and Referral Services collaborated with Operation Lone Star, an annual effort to provide free medical and dental care in south Texas.

Activity 2: In FY12, a total of 2,019 clients received CSHCN SP health care benefits and 879 were on the waiting list due to funding limitations. Of these clients, 466 had no other health care coverage. CSHCN SP assisted 30 families with insurance premium payments.

During the spring and summer of FY12, 948 clients were eligible to receive time-limited health care benefits while maintaining their placement on the waiting list. Contractors and regional staff assisted families in accessing these benefits. CSHCN SP mailed "good news" letters to 155 clients on the waiting list who will begin receiving comprehensive health benefits on September 1, 2012.

The DSHS Council approved revisions to the CSHCN SP rules and approved forwarding them for public comment. Training was provided to eligibility staff statewide to ensure the correct processing of client applications.

Activity 3: Staff distributed information on funding resources for medical needs and improving access to health care to contractors, regional staff, providers and others. The Family Newsletter included articles on the Medical Transportation Program, Medicaid Managed Care expansion, Obesity, Emergency Medicaid, and Tips for Choosing a Doctor. Quarterly conference calls addressed managed care expansion, including dental, and changes impacting CYSHCN.

The DSHS State Dental Director presented at the Baylor College of Medicine's LEAH conference on challenges specific to youth and young adults with special health care needs in accessing dental services.

Performance Assessment: Ensuring that families have health insurance to pay for the services their child needs remained a priority of the CSHCN SP. Staff and contractors continued to help families access services and complete applications for health care benefits. The CSHCN SP health care benefits program continued to provide comprehensive health care benefits to eligible clients and assist in insurance premium payments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.				X
2. 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.	X	X	X	X
3. Activity 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: CHSCN SP staff coordinated with stakeholders, agencies, and others to monitor Medicaid transformation and expansion activities. Under the Texas Healthcare Transformation and Quality Improvement 1115 Waiver, 20 Regional Health Care Partnerships (RHPs) submitted proposals to transform health care delivery. Staff monitored Affordable Care Act (ACA) impacts on CYSHCN and attended HRSA's ACA Peer-to-Peer webinar series.

Activity 2: As of February 28, 2013, a total of 1,339 children received CSHCN SP health care benefits and 712 children were on the waiting list for health care benefits. Of these children, 255 had no other health care coverage. CSHCN SP assisted 19 families with insurance premium payments.

A total of 155 clients were removed from the waiting list on September 1, 2012. Contractors and regional staff assisted families in accessing benefits.

The Quality Management Team began surveying health care benefits families to gauge if needs

are being met and identify reasons for an increase in emergency room use. FQHCs and RHCs began enrolling in the CSHCN SP. Proposed revisions to program rules were sent to HHSC for approval.

Activity 3: Staff and contractors continued identifying outside funding sources for health insurance, sharing pertinent information, and helping families complete applications. The Family Newsletter included articles on managed care and retaining CSHCN SP health care benefits.

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 designed to increase health care coverage, improve benefits, and incorporate evidence-based practices and quality measurement and outcomes.

Monitoring: Review information on progress of ongoing federal health care reform; policy developments of CHIP, Medicaid, and other payers; Texas managed care expansion activities; Stakeholder Meeting Records; staff activity documentation; assessment of impact for CYSHCN families.

Activity 2: Maximize 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 health care benefits including those receiving ongoing services, those on the waiting list who received limited services, those on the waiting list with no other source of insurance, those removed from the waiting list, and those receiving CSHCN SP health care benefits that received Insurance Premium Payment Assistance (IPPA); documentation of efforts to increase number of CSHCN SP providers and outcomes of those efforts.

Monitoring: Review monthly health care benefits client and provider data from TMHP and LBB quarterly performance measure reports.

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

Output Measure(s): Articles published including the CSHCN SP Family Newsletter, provider notices, and other publications; resource information posted on the CSHCN SP website; information shared with and distributed to staff, contractors, providers and others.

Monitoring: Review contractor quarterly reports; meeting minutes; publications; resource information shared.

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

Tracking Performance Measures

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

Annual Objective and	2008	2009	2010	2011	2012
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Performance Data					
Annual Performance Objective	88.3	88.4	88.5	88.6	60
Annual Indicator	88.2	56.6	56.6	56.6	56.6
Numerator	706914	515491	515491	515491	515491
Denominator	801141	910457	910457	910457	910457
Data Source	National Survey of CSHCN	National Survey for 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
	2013	2014	2015	2016	2017
Annual Performance Objective	60	62	62	65	65

Notes - 2012

For 2011-2014, indicator data come 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 mistakes.

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.

a. Last Year's Accomplishments

Activity 1: Over 239,800 calls were made to the 2-1-1 system related to Maternal and Child Health (MCH). There were 38,291 unique visits to the CSHCN Services Program website.

Regional staff and contractors continued to respond to information and referral inquiries. Texas Parent to Parent (TxP2P) was a recipient of the 2012 Emergency Medical Services for Children (EMSC) Recognition Award for work across Texas educating emergency providers on assessment and management of CYSHCN.

Activity 2: The Task Force for Children with Special Needs released its strategic plan and contracted with a marketing firm to conduct a formative assessment, supported in part through Title V funding, in preparation for creating a statewide comprehensive website for families, providers and others. Staff participated in the development of the strategic plan and additional Task Force activities.

Staff continued collaboration with the Newborn Screening Unit to develop resources for families and represented the interests of CYSHCN and their families on numerous interagency and intra-agency workgroups.

Contractors continued helping families navigate complex systems and more easily access services. West Texas Rehabilitation Center provided outreach and support to families of children receiving pediatric specialty services. The Jasper Newton County Public Health District developed a medical equipment recycling program. SHARE collaborated with DSHS and Texas Children's Hospital to host and provide respite for parents attending a genetics conference. They collaborated with TxP2P to create a NICU parent support program. The Arc of San Antonio organized information sessions on guardianship, special needs trusts, and opportunities for youth upon graduation.

Staff participated in the Achieving Successful Systems Enriching Texas Steering Committee's strategic planning activities and supported work to further System of Care initiatives for children with mental health diagnoses. Paso del Norte collaborated to conduct training for family members to become certified Family Partners and help families of CYSHCN with mental health issues navigate systems more easily.

Health care professionals completed CYSHCN relevant THSteps training modules: 1,386 Case Management, 542 Mental Health Screening and 734 Mental, Emotional, & Behavioral Disorders.

Activity 3: Staff presented on People First language at the Children's Special Needs Network's annual conference and provided input on HHSC's draft guidelines for implementing People First Respectful Language subsequent to passage of HB 1481, 82nd Legislative Session. Contractors and staff continued promoting People First Language. The THSteps Cultural Competency module was completed by 1,992 health care professionals.

Activity 4: CSHCN SP contractors and regional staff provided case management, clinical supports, and family supports and community resources to 6,953 clients.

Activity 5: Staff facilitated contractor conference calls to support collaboration and information sharing on Title V priorities. Topics included emergency preparedness, bullying, managed care expansion, and the new Take Time Texas statewide respite resource directory.

Staff spoke on Title V at the 2012 LEAH conference. Activities of the Texas Autism Research & Center and Texas Autism Council were monitored and shared with regional staff and contractors. Staff supported, coordinated, and monitored contractors via ongoing technical assistance, site visits, and other quality assurance activities. Staff utilized and shared information with contractors about the MCH Navigator.

Performance Assessment: Improving access to services and helping families navigate complex

systems remained a priority for the CSHCN SP. Through collaboration with other state and local partners, CSHCN SP staff and contractors continued efforts to improve easy access to community-based services. Clients and families reported high levels of satisfaction with case management, clinical supports, and family supports and community resource services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Collaborate with Texas Information and Referral/2-1-1 system and others to foster and improve effective awareness and linkage to community services and supports for CYSHCN and their families.				X
2. Activity 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. Activity 3: 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. Activity 4: Provide comprehensive case management, family supports, and community resources through the CSHCN SP.			X	
5. Activity 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: CSHCN SP and 2-1-1 staff met to identify ways to better support CYSHCN families in finding and accessing needed services. Texas' Amber Alert Coordinator presented on the Endangered Missing Persons Alert Network for people with an intellectual disability to contractors and regional staff. Contractors continued efforts to educate families on emergency preparedness.

Activity 2: Collaboration continued between CSHCN SP staff and various workgroups including the Children's Policy Council (CPC), Consumer Directed Services Workgroup, and Project Access. The CPC submitted its biennial legislative report with a recommendation to create a single entry point website to help families find services more easily.

The Task Force for Children with Special Needs reported findings on the need for a multi-agency website devoted to CYSHCN. HHSC initiated development of a RFP process to develop the site.

Activity 3: Agencies continued updating state statutes and other documents in adherence to People First Language legislation requirements. To date, 487 individuals completed THSteps' Cultural Competence module.

Activity 4: CSHCN SP contractors and regional staff provided case management, clinical supports, and family supports and community resources to 3,835 clients.

Activity 5: Staff presented, "Understanding the Texas Title V Program for CYSHCN" at the LEAH conference. A contractor call featured the Research Coordinator at the National Center for Ease

of Use of Community-Based Services.

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): Number of 2-1-1 calls related to Maternal and Child Health; utilization of 2-1-1 webpage; efforts to increase 2-1-1 family resources and inform 2-1-1 staff of CYSHCN issues; documentation of staff and contractor emergency preparedness activities; documentation of information and referrals from regional staff and contractors.

Monitoring: Review quarterly 2-1-1, contractor and other reports; resource information shared; meeting minutes; Stakeholder Meeting Records; trainings attended; reports of other 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): Active participation by staff and contractors in key collaborative initiatives; reports identifying key issues, emerging/unmet needs, and recommendations to guide Title V activities; utilization of the THSteps training modules relating to CYSHCN.

Monitoring: Review Stakeholder Meeting Records; meeting minutes; contractor quarterly reports; publications; documentation of collaborative activities; THSteps 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; utilization of the THSteps Cultural Competence training module.

Monitoring: Review media, staff activities, THSteps training module data, and contractor quarterly reports; Quality Assurance (QA) activities and technical assistance provided; resource material shared.

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

Output Measure(s): Number of CYSHCN receiving case management, clinical supports, 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; contractor conference call minutes; meetings with regional staff; technical assistance efforts and site visit reports.

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 conference calls to promote innovation

and best practice; technical assistance and training provided for relevant groups.

Monitoring: Review contractor conference call meeting minutes; training, education, and technical assistance efforts

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	37.2	37.3	37.4	37.5	37.6
Annual Indicator	37.1	35.4	35.4	35.4	35.4
Numerator	107424	101253	101253	101253	101253
Denominator	289879	286298	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
	2013	2014	2015	2016	2017
Annual Performance Objective	37.7	37.8	37.9	37.9	37.9

Notes - 2012

For 2011-2014, indicator data come 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 mistakes.

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.

a. Last Year's Accomplishments

Activity 1: CSHCN SP contractors and regional staff provided transition case management for 2,007 CYSHCN. 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. The THSteps Case Management Transition module was completed by 319 professionals and 707 individuals completed the Adolescent Health Training module. CSHCN SP staff provided subject matter expertise for annual revisions to these modules. Staff distributed transition resources to 289 case managers and others throughout Texas.

Activity 2: CSHCN SP provided funding for 36 families, including seven youth, to attend the 2011 LEAH conference. An additional 36 people attended via remote site telecast. CSHCN SP staff presented at the 2012 conference. Staff helped plan the LEAH conference, the TxP2P Annual Conference, and the transition Teen Summit held during the TxP2P conference for youth both with and without disabilities. CSHCN SP staff continued to be available for the Transitioning Youth Subcommittee of the Task Force for Children with Special Needs. Regional staff participated in area transition events throughout the state. Staff exhibited at a "Destination Fair" sponsored by Central Texas area high schools and presented at the Children's Special Needs Network's annual conference.

TxP2P was awarded funds to implement "Pathways to Adulthood" workshops over three years. The program trains parents of CYSHCN to help other parents of transition-age youth to access quality, comprehensive, coordinated, community-based services. Statewide action teams began forming to connect parents of CYSHCN and create social groups for youth. CSHCN SP staff has partnered with TxP2P to help ensure the program's success.

Activity 3: CSHCN SP staff convened quarterly Transition Team meetings exchanging information about upcoming events and best practices. Topics included disability disclosure in the workplace, Disability Navigators, an overview of transition issues addressed by the 2011 Texas Legislature, and updates of new programs from TxP2P and Coalition of Health Services.

Activity 4: CSHCN SP staff engaged stakeholders, made presentations, and led or participated in state- and regional-level workgroups to advance promising transition practices. Staff presented at the Texas School Nurses Organization Conference, Region XII Education Service Center (ESC) Transition and 18+ Network meetings, and the Texas Transition Conference.

State and regional-level workgroups participation included the Task Force for Children with Special Needs, Community Resource Coordination State Work Group, Texas Council for

Developmental Disabilities, Region XII ESC Transition and 18+ Networks, Council on Children and Families, and the Department of Assistive and Rehabilitative Services (DARS) Central Texas Transition Forum.

CSHCN SP renewed the LEAH contract for families to attend the annual conference. At the 2012 AMCHP Conference, the LEAH Program exhibited two posters about their 2011 conference and collaboration model. Dr. Albert Hergenroeder, Baylor College of Medicine, presented findings evaluating provider use, health care transition knowledge, and satisfaction with a Transition Planning Tool (TPT) at this conference and the Pediatric Academic Society's annual meeting. Findings identified that 92% of TPT users wanted to use the TPT more often.

Performance Assessment: Program planning and development continued to be informed by stakeholder priority and themes. Staff and contractors continued efforts to improve transition case management, increase information and training opportunities for families and professionals, collaborate with education and rehabilitation partners, and participate in state-level transition forums. The Transition Team and other initiatives such as the LEAH conference increased awareness of transition for families, physicians, state agency personnel, and others.

An attachment is included in this section. IVC_NPM06_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Provide transition case management for CYSHCN through CSHCN SP regional staff and contractors.		X		
2. 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.				X
3. Activity 3: Lead the PHSU Transition Team, including CSHCN SP staff and contractors, to coordinate and enhance CSHCN SP transition activities.				X
4. Activity 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 transition projects and other stakeholders.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: THSteps Transition and Adolescent Health modules were completed by 109 and 346 professionals, respectively. CSHCN SP regional staff and contractors provided transition case management for 1,012 CYSHCN and their families to access medical and non-medical services. CSHCN SP staff distributed transition resources to 281 professionals statewide.

Activity 2: CSHCN SP staff worked with high school educators through ESCs, participated in two transition fairs, and attended Partner's Resource Network's "Beyond the ARD" workshop and the 2013 Texas Transition Conference.

Activity 3: Transition Team meeting topics included the disABILITY Advocate Program at the University of Texas/Austin, Houston HEART, and Dallas Bridges from School to Work. To

increase transition readiness, CSHCN SP convened the Transition Toolkit Workgroup, which began developing a program policy on transition and compiling resources to create a toolkit for CYSHCN and families.

Activity 4: CSHCN SP staff continued to serve on the planning committee for the Chronic Illness and Disability (transition) Conference. CSHCN SP's contract with Baylor College of Medicine (BCM) continued funding three initiatives: family attendance at the transition conference, transition training for interns, and promotion of the BCM/Texas Children's Hospital Transition Planning Tool. A total of 33 family members and youth attended the transition conference and at least 52 individuals attended via remote sites across the state.

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): Utilization of online THSteps Transition Case Management and Adolescent Health training; number of CYSHCN receiving individual transition services (medical and non-medical) from contractors and regional staff.

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

Activity 2: Partner with CYSHCN, their families, providers, and others to share information and guide CSHCN SP transition activities.

Output Measure(s): Input/guidance received on transition activities from CYSHCN and their families, providers and others; contractor activities; publications authored for/presentations given to CYSHCN, families, providers, and others.

Monitoring: Review Stakeholder Meeting Records; regional and contractor case management quarterly reports; publications/presentations.

Activity 3: Lead the CSHCN SP Transition Team, including CSHCN SP central office and regional staff, contractors and others to coordinate and enhance CSHCN SP transition activities.

Output Measure(s): Transition team activities; exchanges with contractors, regional staff and others to discuss transition activities; Transition Toolkit Workgroup initiatives.

Monitoring: Review meeting minutes and publications including contractor quarterly reports.

Activity 4: Provide leadership to promote best and promising practices and improve access to transition services.

Output Measure(s): Utilization of and updates to the CSHCN SP Transition webpage; participation in planning, information reported, and attendance at transition-related meetings or conferences; resources provided to regional staff, contractors and other professionals statewide.

Monitoring: Review resource information shared; trainings developed; meeting minutes; Stakeholder Meeting Records; CSHCN SP Transition webpage; 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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	80	80	81	80	77
Annual Indicator	78.6	74.4	76.3	76.3	77.2
Numerator	431060	412459	430989	418229	416230
Denominator	548422	554380	564742	548138	539159
Data Source	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	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	78	79	79	80	80

Notes - 2012

US, National Immunization Survey, 2011. The denominator is the population of 2 and 3 years olds adjusted proportionately to estimate the population of 19-36 month olds. Population numbers are from the Texas Data Center from the Office of the State Demographer.

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 2006-2011 are final.
2011 denominator based on population projections for 2011 from State Data Center of the Office of the State Demographer.

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.

a. Last Year's Accomplishments

Activity 1: Local health department (LHD) contractors identified and maintained partnerships with 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. Four LHDs piloted immunization collaborations to enhance partnership development and collaboration at the local level across Texas. These efforts occurred in Corpus Christi, San Patricio County, greater Northeast Texas and Angelina County Public Health Departments.

The Texas Immunization Stakeholders Work Group (TISWG) met on December 8, 2011, March 22, 2012, and June 21, 2012. These meetings included more than 70 participants and discussions focused on new bacterial meningitis vaccine requirements and a related action plan for students at institutions of higher education in Texas.

In Summer 2012, the DSHS Immunization Branch launched the "Protect 2 from the Flu" campaign to encourage and prompt pregnant women to get the flu vaccine. OB/GYNs and pregnant women received print materials, patient brochures, and radio, web-based and mobile application advertisements. Campaign messages directed stakeholders to the campaign website and the mobile-ready platform created to educate pregnant women about the flu and the benefits of receiving the flu vaccine. In addition, a paid television ad ran on network and cable in four large urban markets: Dallas/Fort Worth, El Paso, Houston, and San Antonio, which included about 65% of all women 18-34 in the state. It was also sent as a free public service announcement to all TV stations statewide.

Activity 2: LHD contractors conducted 1,353 trainings and/or technical assistance requests on the use of ImmTrac, the state immunization registry. The Immunization Branch conducted trainings and responded to 1,996 technical assistance requests on the Vaccines for Children program. Training, education and technical assistance continued to increase due to the passing of SB 346, 81st Legislature, Regular Session, allowing persons to maintain their immunization information longer in ImmTrac. ImmTrac and Texas Vaccines for Children (TVFC) at Central Office continued training, education, and assistance to the Health Service Regions and Local Health Departments on TVFC and ImmTrac processes as they are updated to meet demand, grant requirements and legislation.

Performance Assessment: Data indicates the percentage of 19 to 35 month olds receiving their full schedule of age-appropriate immunizations continued to remain stable. Staff continued to identify and develop activities and partnerships with internal and external stakeholders to raise vaccine coverage levels.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Activity 1: Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.				X
2. 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.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: LHD contractors continued supporting immunization initiatives with 74 partnerships. DSHS provided information to immunization partners through the TISWG, the DSHS website, and other local health departments. An increased effort to reach out to stakeholders started by distributing suggested activities and information for National Infant Immunization Week.

The pilot at four LHDs to enhance partnership development and collaboration ended December 31, 2012.

Activity 2: The 50 LHDs provided 451 trainings and 301 technical assistance requests on ImmTrac. The LHDs also conducted 659 trainings and 439 technical assistance requests on the TVFC program.

Training, education and technical assistance continued to increase due to the Texas Health & Safety Code, Chapter 161, Section 161.0095 rule requirements, the ImmTrac Replacement Project, Health Level 7 Interoperability Project for electronic files related to health data transmission, and the Vaccine Tracking System (VTrckS) Project for ordering and tracking vaccines for children. Immunization staff continued to promote, provide training, and assist the DSHS regional staff and LHDs on ImmTrac and TVFC processes. Several processes have changed due to updated demands, grant requirements, and legislative mandates.

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. The measure will be reported via the LHD Quarterly Reports under the Education, Information, Training and Collaborations.

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

Output Measure(s): Number of state, regional and local activities that promote participation in the

state immunization registry and the TVFC program; number of training and awareness activities; number of technical assistance activities provided.

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	2008	2009	2010	2011	2012
Annual Performance Objective	32	32	32	34	26
Annual Indicator	34.9	33.1	29.2	27.2	24.2
Numerator	18934	17907	16015	14015	13150
Denominator	542343	540995	547814	515779	544040
Data Source	Nativity 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?				Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	24	24	23.5	23.5	22

Notes - 2012

Numerator is from the 2012 birth file. 2012 birth data are preliminary and subject to change. Denominator is the 2012 projected population from Texas State Data Center of the Office of the State Demographer.

Notes - 2011

2011 birth data are provisional and will be finalized Aug 2013. 2011 population data are based on population estimates from Texas Data Center of the Office of the Texas State Demographer.

Notes - 2010

Update June 2012: Natality data for 2010 is finalized.

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

a. Last Year's Accomplishments

Activity 1: DSHS examined the Youth Risk Behavior Surveillance Survey data received in October 2011 to identify behaviors that may be associated with early childbearing and behaviors related to positive youth development. An analysis of the number of reported developmental assets (talking to parents about school at least once/week, spending at least one hour/week in school based activities, etc.) and sexual activity (ever had sex, sex before age 13, and having had sex with four or more partners) showed that the rate of sexual activity has a negative relationship with the number of developmental assets reported.

The Texas School Health Network and DSHS regional staff participated in local teen pregnancy prevention activities and provided training and support to local coalitions, providers, school districts, and other community members. Regional staff attended 243 meetings and shared teen pregnancy prevention data and/or participated in prevention activity planning or implementation.

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

El Paso and Hidalgo counties' coalitions continued strategic planning on adolescent pregnancy and included 39 community partners to plan local teen pregnancy prevention community activities. The El Paso County Teen Pregnancy Prevention Coalition hosted a two-part workshop helping members learn how to work with youth in advocacy and organizing efforts and use social networking and social media in promoting their message. A total of 34 people representing 22 different organizations attended the workshop. The Rio Grande Valley Coalition started planning a conference in San Antonio involving the Latina/o family and the importance of families talking together, and panels from teen parents and community resources.

The Third Annual Texas Youth Leadership Summit featured large and small group sessions on leadership, goal setting, decision making and serving learning. The event was attended by 130 youth and sponsors from Texas youth leadership clubs.

A teen pregnancy prevention webinar series was attended by 98 people during FY12. Webinar topics included: Teen Pregnancy - Risk and Protective Factors, Prevalence, and Other Statistics; Evidence-Based Programs - General Criteria and Components; and Implementing Teen Pregnancy Prevention Programs in School Systems - What You Need to Know.

DSHS purchased a media buy for a six-week period to direct students and parents to online Power2Wait resources. The campaign initiated a total of 227,682 visitors to Power2Wait.com, Power2Talk.org, and poderdehablar.org during the campaign.

DSHS distributed 98 Power2Wait toolkits and 23,368 brochures, workbooks and DVDs to school districts, community organizations, and state and local government agencies.

Activity 3: The six Texas Healthy Adolescent Initiative (THAI) sites completed and disseminated media projects. Topics included healthy relationships, communication, education, reframing the perception of youth, and other asset building topics. Youth created and produced the media projects while making the projects relevant to youth in each of the communities. The City of Houston project included a discussion and facilitator's guide to promote an interactive dialogue among young people, parents, community members, and others by using the media project as the vehicle for those discussions. The Sequor Youth Development Initiative at Texas A&M Agrilife Extension Services began an evaluation of the Texas Healthy Adolescent Initiative to provide an independent assessment of the implementation and impact of the each of the six THAI sites using a mixed methods approach to investigate the implementation as well as impact of each THAI site on young people and the local communities. The evaluation, with an expected completion of August 2013, will identify best practices among the THAI sites.

Performance Assessment: Based on provisional data, Texas saw a 3% decrease in the rate of adolescent births in 2012 and more than 10% over the last five years. Focused outreach efforts along with social media messaging should continue supporting further decreases in births and support healthy decision making

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Coordinate educational and awareness activities to increase understanding of teen pregnancy prevention, including disparities (racial/ethnic, geographic) in rates.				X
2. 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 adolescent pregnancy.			X	X
3. Activity 3: Implement Texas Healthy Adolescent Initiative in local communities.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Staff coordinated and participated in meetings, workshops, presentations, events and other activities to promote healthy youth development and to share teen pregnancy prevention data and strategies.

Activity 2: Abstinence-Centered Teen Pregnancy Prevention contractors implemented curricula and service learning projects, serving 3,879 youth and 692 parents in 11 counties. Four community coalitions continued activities and strategic planning for adolescent pregnancy prevention. DSHS provided web-based resources and distributed 9,480 "Sex Can Wait, Talking Can't" booklets and DVDs for parents along with 44 Power2Wait Toolkits for schools and community organizations serving youth. Training was provided to 51 Power2Wait facilitators.

Activity 3: The six THAI sites started developing sustainability plans to identify strategies,

resources and action steps for continuing education, training, youth engagement, and promoting inter-organizational collaboration efforts to successfully identify and solve local problems facing youth beyond the funding period. The Sequor Youth Development Initiative at Texas A&M Agrilife Extension Services completed a preliminary assessment report. A youth-led research project to be implemented in Summer 2013 in many THAI communities will provide youth perspectives on the impacts of THAI in their community.

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; number of teen pregnancy prevention activities provided through the Texas School Health Network.

Monitoring: Maintain copies of materials or products distributed; summarize 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; develop 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; track quarterly progress reports.

Activity 3: Continue to implement Texas Healthy Adolescent Initiative programs in local communities.

Output Measure(s): Number of contractors; number and type of activities conducted by contractor.

Monitoring: Document materials and plans developed; track quarterly progress reports; track outcomes.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	34.4	37	37	37	37
Annual Indicator	34.4	34.4	34.4	34.4	34.4
Numerator	122241	126694	129149	130514	131074
Denominator	355351	368296	375432	379400	381029
Data Source	Texas	Texas	Texas	Texas	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	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	37	37	39	39	39

Notes - 2012

The oral health sealant data is collected only once every 5 years. The last completed data collection was in 2007-2008. Texas is currently collecting data for school year 2013. The 2012 enrollment figure was not available at time of reporting. Enrollment is estimated based on the percentage of 8 and 9 year olds in the population enrolled in 3rd grade for 2011.

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.

a. Last Year's Accomplishments

Activity 1: The DSHS Oral Health Program (OHP) regional dental teams provided limited oral evaluations to 10,955 third grade children. Of these children, 4,690 (42.8%) were provided dental sealants through school-based and Head Start preventive dental services (PDS) projects. A total of 18,416 sealants were placed for an average of 3.9 teeth sealed per child.

Activity 2: DSHS OHP regional dental teams identified 3,349 (30.5%) children with untreated caries through limited oral evaluations provided during school-based and Head Start PDS projects.

Activity 3: A total of 3,349 (30.5%) third grade children that received limited oral evaluations were referred for follow up dental care through results of the limited oral evaluation. Additionally,

10,063 (91.8%) children were determined to be program eligible and were provided access to preventive 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.

Performance Assessment: The number of 3rd graders receiving protective sealants continues to grow in proportion to the overall number of 3rd graders in Texas. Compared to 2011, 466 more children were screened by the teams and the percentage receiving sealants increased from 35.1% to 42.8%. These increases, along with increased demand for dental services in the fee-for-service contracts identify the strong need for dental services for youth across the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Continue providing dental sealants to Texas school children.	X			
2. Activity 2: Monitor data on the number and percent of third graders with untreated caries.				X
3. Activity 3: Increase access to preventive dental care services through school-based efforts.	X		X	
4. Activity 4: Collaborate with stakeholders to develop oral health promotion activities and materials for providers and recipients of services.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: As of February 28, 2013, the DSHS OHP regional dental teams provided 6,903 dental sealants to 1,886 unduplicated children for an average of 3.66 sealants per child.

Activity 2: The DSHS OHP regional dental teams performed limited oral evaluations on a total of 6,465 children ranging from preschool through 6th grade. Of the 6,465 children evaluated, 1,875 (29%) had untreated caries.

Activity 3: Efforts continue with school nurses and Head Start health coordinators to provide parents and caregivers written results of the limited oral evaluations, along with referrals for additional dental evaluation and treatment were provided for all of the 1,875 children identified.

Activity 4: During the first half of FY 2013, DSHS OHP staff worked with Title V, Texas Health Steps, Primary Health Care Services and other collaborative partner staff to develop oral health promotion activities. With a proposed exceptional item aim at expanding health care services for low-income women, OHP staff worked in identifying which the oral health services to be offered, as well as ways to engage local dental resources in providing services to this population.

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 unduplicated children provided with preventive dental services through school-based efforts and referrals made.

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.

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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	4.7	4.7	4.6	4	2.8
Annual Indicator	3.5	3.4	3.0	2.8	3.6
Numerator	188	187	173	156	207
Denominator	5384151	5449069	5738590	5608144	5788478
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	Mortality 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?				Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	2.8	2.7	2.7	2.6	2.6

Notes - 2012

Death data are from the 2012 preliminary death file and subject to change. Population data for 2012 are from the Texas State Data Center from the Office of the State Demographer.

Notes - 2011

2011 data are based on a provisional death file for 2011. This file will be finalized in Aug 2013.

Notes - 2010

June 2012: Mortality data for 2010 are final.

Denominator data are projections by the Office of the State Demographer.

a. Last Year's Accomplishments

Activity 1: DSHS Safe Riders program provided 5,365 child safety seats to six local organizations contracted by the Texas Department of Transportation (TxDOT) to distribute seats during child safety seat check-ups. Local partners presented 1,103 educational classes about child passenger safety, and distributed 6,950 child safety seats to qualifying families.

Activity 2: DSHS Safe Riders program hosted four Child Passenger Safety (CPS) technician courses in geographically distinct areas of Texas: Austin, Lubbock, Longview, and Laredo. The courses trained and certified individuals as CPS technicians to conduct child safety seat check-ups in their local communities. A total of 38 new CPS technicians completed the course and were certified.

Activity 3: DSHS Safe Riders staff made 43 presentations on traffic safety to 876 individuals, including parents of teens, state agency staff, families, and other community groups. DSHS regional staff participated in over 350 motor vehicle safety activities including health fairs, child seat safety checks and distribution, and other safety activities through Injury Prevention Coalitions, school districts, WIC clinics, juvenile detention centers, Safe Kids coalitions, public libraries, outreach to migrant families and refugees, and Child Fatality Review Teams (CFRTs).

Staff checked or installed 900 car seats and distributed over 600 car seats. Several DSHS regional sites registered to become National Highway Traffic Safety Administration (NHTSA) inspection stations. Statewide, regional staff conducted bicycle rodeos, instructing on bicycle

safety and distributing free bicycle helmets.

DSHS regional staff in East Texas worked to increase All-Terrain Vehicle (ATV) safety through work with the ATeamV coalition. They collaborated with 4-H, Department of Public Safety, and Parks and Wildlife to review ATV safety trainings. Regional staff presented on ATV injuries to 50 physicians attending Grand Rounds at the University of Texas Health Science Center at Tyler. They were active in the Pay Attention East Texas (PAET) coalition, a multi-county, disciplinary group focused on motor vehicle safety and worked on development of a PSA about texting while driving. Additionally, regional staff participated in the Safe Kids' Never Leave Your Child Alone in a Car (NLYCAC) campaign to prevent vehicular hyperthermia of infants and young children left in cars. Staff provided education to parents and caregivers about the risks to kids in hot cars during child safety seat check-ups.

Activity 4: The State CFRT submitted recommendations to the governor and legislators regarding child safety. Several recommendations focused on motor vehicle safety, including a ban on driver use of a wireless device unless device is hands-free, repeal of the statute allowing parent-taught driver education, legislation to require parents/guardians to attend motor vehicle traffic hearings of minors, and legislation that makes it an offense if a driver operates a motor vehicle on a public highway with any detectable alcohol in the driver's system while transporting a minor.

The SCFRT workgroup began updating the Motor Vehicle Safety position statement. CFRTs reviewed 356 motor vehicle and transportation-related deaths in FY12. Of those deaths reviewed, 72% were car occupants (passenger or driver) and 22% were pedestrians. CFRTs conducted multiple activities to reduce motor vehicle crash deaths. Many teams participated in child safety seat check-ups and seat distribution events. Two teams collaborated with agricultural extension offices to conduct Agriculture Safety Days, where elementary students learned about the importance of using seatbelts and ATV safety. Three CFRTs conducted child safety seat/seatbelt use surveys at local schools to measure the safety of children when transported to and from school. CFRTs promoted the risks of texting and driving. Statewide, CFRTs were part of the NYCLAC campaign, distributing educational materials, training parents and caregivers, and using print and broadcast media to inform the public about the dangers of leaving kids in cars.

Performance Assessment: Data indicate an increase in the rates of data reported in previous years. DSHS believes this is an anomaly as the increase is specific to one age group. Staff will continue to monitor this data in the upcoming year and continue collaboration with CFRTs and other groups to promote education and distribution of child safety seats.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Distribute child safety seats to low-income families via educational classes throughout the state.			X	
2. Activity 2: Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.				X
3. Activity 3: Conduct traffic safety presentations throughout the state and health service regions.			X	
4. Activity 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.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Activity 1: At mid year, Safe Riders distributed 1,831 child safety seats through 58 local programs working with low-income families during safety seat checkups. A total of 507 educational classes were offered to recipients of child safety seats.

Activity 2: Two CPS technician training courses were conducted, training a total of 27 new CPS technicians in Amarillo and Round Rock.

Activity 3: Safe Riders conducted 15 traffic safety presentations to 286 participants. DSHS regional staff participated in over 200 motor vehicle safety activities, including health fairs, car seat safety inspections and seat distribution, and training on ATV safety. Over 1,000 seats were checked or installed by regional staff. Several DSHS regional sites registered to become NHTSA inspection stations.

Activity 4: The SCFRT recommended to the Governor & State Legislature a ban on driver use of wireless devices unless the device is hands-free, repealing the law allowing parent-taught driver education, and a statute to require a parent/guardian attend MV traffic hearings when driver is under 18 years of age. The SCFRT researched, updated, and posted their Motor Vehicle Safety for Children Position Statement.

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; number of safety seats issued to participating organizations; 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; evaluate the ease of access to safety seats.

Activity 2: Conduct national 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); track number of students per course; track number of update/renewal classes per year; track number of students per class.

Activity 3: Conduct traffic safety presentations and other related activities throughout the state.

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); review 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): Development of Annual Child Fatality Review Team (CFRT) 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; appropriate prevention strategies at CFRT Annual and other Conferences; recommendations for PSAs.

Monitoring: Track updates on child deaths, prevention and training activities, and potential recommendations at quarterly State CFRT Committee meetings.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	37	48.5	56	51	54
Annual Indicator	46.9	48.5	50.0	51.6	53.3
Numerator	189896	194919	192873	194540	207727
Denominator	405242	401610	385746	376684	389901
Data Source	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
	2013	2014	2015	2016	2017
Annual Performance Objective	54	56	56	58	58

Notes - 2012

2010, 2011, and 2012 data are projections from the National Immunization Survey (NIS) based on 2004-2009 data. 2009 was the most up-to-date data available at time of reporting. From the NIS, the reported percentages for 2007 is 48.7%, 2008 is 42.2%, 2009 it is 50.7%.

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.

a. Last Year's Accomplishments

Activity 1: There were more than 200,000 visits to the DSHS breastfeeding website and mobile site for mothers and families, BreastmilkCounts.com, and 3,513 visits to the DSHS WIC Peer Counselor webpage. Educational materials available for download or distributed included a total of 142 unique items related to breastfeeding. These items were available for download from the WIC website or for hard-copy distribution. Activities included coordination and participation in national, state and local coalitions, community partnerships. Staff presented at national and statewide conferences, meetings, and teleconferences. A new website, SupportFromDayOne.org, was developed to support outreach partners to develop activities related to the Surgeon General's Call to Action to Support Breastfeeding. Three WIC Lactation Resource Training Centers and eight Texas Baby Café-designated drop-in centers received support services. Varied state and federal funding sources supported multiple local communities to implement strategies to increase breastfeeding in Texas communities. The August 2012 Born-to-WIC breastfeeding initiation rate was 82.5%.

Activity 2: There were 81 Texas Ten Step (TTS) hospitals, seven Baby-Friendly Hospitals (BFH), and 25 hospitals registering intent for BFH. DSHS conducted 220 health professional training sessions reaching 4,911 professionals. A total of 5,987 web-visits occurred on the TexasTenStep.org website. The THSteps updated the online continuing education breastfeeding module. Development continued for a 20-hour online training module for hospital staff. All Texas birthing hospitals received data reports and educational booklets. Six webinars were conducted. Recruitment began for the Texas Ten Step Star Achiever Breastfeeding Learning Collaborative for hospitals to increase in-hospital exclusive breastfeeding through rapid cycle quality improvement.

Activity 3: Implementation of the CDC Communities Putting Prevention to Work-funded Texas Mother-Friendly Worksite (MFW) Policy Initiative continued. Staff completed MFW program rules revisions to align with federal employer requirements and to add new designation levels. Information gathered through focus groups and interviews with over 200 employers, parents and outreach partners was used to develop a communication strategy, materials, and the TexasMotherFriendly.org website, including six online videos, success stories, support pledges, an employer toolkit, and an outreach partner toolkit. The campaign resulted in more than 200 million impressions, 40,150 visits to TexasMotherFriendly.org and 15,196 visits to breastmilkcounts.com/working-moms.php between May and August. A sustainability plan and

components of an evaluation plan were drafted. Five local communities received state and federal funds to increase the number of MFW employers. A total of 1,120 MFWs were designated by the end of FY12 for a 481% increase from 2010. The Texas Breastfeeding Coalition was awarded the National Worksite Breastfeeding Support for Employers of Overtime Eligible Employees Initiative grant to develop a national online resource of worksites that support breastfeeding employees.

Activity 4: A MFW policy was adopted for all five HHS agencies. Staff provided technical assistance on breastfeeding support activities to state and local breastfeeding coalitions, state agencies, local health departments, WIC local agencies, and other states' health departments. The DSHS Infant Feeding Workgroup coordinated initiatives to increase breastfeeding initiation, duration, and exclusivity by agency staff within OTV&FH, OPDS, WIC, and Nutrition, Physical Activity and Obesity Prevention Program, along with Building Healthy Texans Statewide Agency Wellness Program, the Transforming Texas-Healthy People in Healthy Communities Initiative, the Texas Coordinated Chronic Disease Initiative, and the Heart and Stroke Healthy City Initiative. Additional initiatives were coordinated through the Texas Department of Agriculture's Child Care Wellness Grants. Breastfeeding promotion was included as a preventive strategy in the 2012 Texas Cancer Plan and the Texas Plan to Reduce Cardiovascular Disease and Stroke.

Performance Assessment: Any breastfeeding at 6 months continues to steadily increase year-over-year. However, exclusive breastfeeding at 6 months show little change. DSHS continues to strengthen and integrate efforts across sectors to address breastfeeding support barriers and disparities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Develop promotion and support of breastfeeding in the community.			X	X
2. Activity 2: Develop promotion and support for breastfeeding in health care systems.			X	X
3. Activity 3: Develop promotion and support for breastfeeding in the workplace.			X	X
4. Activity 4: Increase integration of breastfeeding promotion and support into DSHS programs.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: So far this year, there were 23,411 website visits to BreastmilkCounts.com, 2,053 visits to the DSHS WIC Peer Counselor page, and 194 visits to SupportFromDayOne.org. Activities included coordination, communication and participation in national, state and local coalitions, community and governmental partnerships, conferences, meetings, and teleconferences. Varied funding sources supported multiple local communities to implement breastfeeding support strategies. The February Born-to-WIC breastfeeding initiation rate was 83%.

Activity 2: There were 96 TTS hospitals, seven Baby-Friendly Hospitals, and 20 TTS Star Achiever (SA) hospitals. There were 5,329 visits to TexasTenStep.org. A collaborative learning session and 80 DSHS health professional trainings were held. The Texas Breastfeeding Coalition hosted continuing medical education for 42 providers from TTS SA and CDC's BestFed

Beginnings hospitals.

Activity 3: There were 3,341 visits to TexasMotherFriendly.org. State and local funds supported five local communities to increase the number of MFW employers. MFW information was disseminated through presentations and exhibits.

Activity 4: Breastfeeding support initiatives were coordinated through the DSHS Infant Feeding Workgroup. Breastfeeding indicators were incorporated into the Heart and Stroke Healthy City assessment. An HHS Enterprise employee breastfeeding class was held. Technical assistance was provided to state and local breastfeeding organizations

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): Rates of any and exclusive breastfeeding; types of attitudes and experiences related to breastfeeding; number and types of population-based and infrastructure-building activities to increase breastfeeding support in the community.

Monitoring: Reports from DSHS Infant Feeding Workgroup member activities; National Immunization Survey, CDC Breastfeeding Report Card, WIC Infant Feeding Practices Survey, Behavior Risk Factor Surveillance System; Texas Breastfeeding Coalition activities.

Activity 2: Develop promotion and support for breastfeeding in health care settings.

Output Measure(s): Number of Texas Ten Step Hospitals, Number of Baby Friendly Hospitals; Number and types of population-based and infrastructure-building activities to increase breastfeeding support in health care settings.

Monitoring: Program data; report of Infant Feeding Workgroup activities.

Activity 3: Develop promotion and support for breastfeeding in the workplace.

Output Measure(s): Number of Texas Mother-Friendly Worksites; number and types of population-based and infrastructure-building activities to increase breastfeeding support in the workplace.

Monitoring: Program data; report of Infant Feeding Workgroup activities.

Activity 4: Increase integration of breastfeeding promotion and support into DSHS programs.

Output Measure(s): Number and types of partnerships developed and 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)]

Annual Objective and Performance	2008	2009	2010	2011	2012

Data					
Annual Performance Objective	96	94	94	94	96.5
Annual Indicator	93.1	95.8	96.0	96.3	95.9
Numerator	383596	391126	376976	369769	373745
Denominator	412099	408391	392752	384071	389901
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?				Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	96.5	96.5	96.5	96.5	96.5

Notes - 2012

The denominator is from the 2012 preliminary birth file and subject to change. The numerator is final.

Notes - 2011

Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence. The denominator is from the 2011 provisional birth file. These data will be finalized in Aug 2013.

Notes - 2010

Update: 2010 births are final.

Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence.

a. Last Year's Accomplishments

Activity 1: The TEHDI Program proposed refinements to the current certification and compliance process to include a change from monthly compliance monitoring to a bi-monthly report card. The certification and report card process were reinstated in January 2013. Staff completed compliance reviews in the first quarter of FY12. The TEHDI Program monitored 256 facilities for adherence to performance metrics. At the end of the first quarter, 79 facilities were noncompliant while 177 facilities were in compliance.

The certification process provides birthing facilities with a rating based on performance metrics. Facilities receive one of the following ratings: distinguished, standard, provisional, or preliminary.

Of the 69 birthing facilities certified during FY12, 42 (60.9%) were distinguished, five (7.2%) were standard, 21 (30.4%) were provisional, and one (1.5%) was preliminary. The next certification will be in July 2013 with an estimated 82 facilities due for review.

Activity 2: During FY12, 376,413 infants born in facilities reported needing a newborn hearing screen. Of those newborns, 99% (373,332 newborns) received a hearing screen, of which 98% (364,403 newborns) passed the screening. Additionally, 3% (10,973 newborns) required follow-up upon discharge including 1% (2,044 newborns) who missed the screening and 2% (8,929 newborns) who did not pass the birth screen.

Activity 3: DSHS distributed 873,302 educational materials during FY12. The program exhibited at seven conferences during FY12, including Texas Pediatric Society conference (300 attendees), Texas Academy of Audiology conference (500 attendees), Early Hearing Detection and Intervention National Conference (500 attendees), Texas Speech, Language, and Hearing Association Convention (4,500 attendees), Texas Woman, Infants, and Children Conference (600 attendees), Community Health Workers Across Texas (300 attendees), and Texas School Ready! Summer Institute (1000 attendees). The TEHDI Program staff presented three trainings using the Prenatal module by the end of FY12 with trainers from University of Texas School of Nursing. The TEHDI Program launched an online prenatal education module in FY12. The TEHDI data system contractor hosted two trainings for audiologists during FY12.

A total of 37 doctors, 153 nurses, nine physician assistants or nurse practitioners, four speech, language and hearing providers, eight social service provider and 41 others completed the online educational module on newborn hearing screening.

Activity 4: The TEHDI data system contractor performed 12 web-based TEHDI e-trainings in Spanish (2 for medical home and 10 for birthing facilities). The UT Nursing staff conducted 12 CE accredited Universal Newborn Hearing Screening (UNHS) presentations and the TEHDI Program hosted 2 non CE UNHS presentations. In addition, the TEHDI Program conducted seven teleconferences to birthing facility staff. During FY12, 156 users completed the TEHDI Program UNHS module webinar (85 users viewed the self-paced online version and 71 users attended a live version hosted by TEHDI data system contractor).

The TEHDI Program and TEHDI data system contractor continued monthly postcard notification to all primary care providers who have patients that need follow up care. Provider Access surpassed 660 users that logged into the system. There were 317 new requests in FY12 for usernames and passwords.

Performance Assessment: Preliminary data indicated that the state has again surpassed the Healthy People 2020 target of 90.2%. With new educational materials released in FY11, the number of materials distributed in FY12 nearly doubled from the previous year. Education and outreach remain high priorities for the TEHDI program moving into FY14.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria.			X	
2. Activity 2: Evaluation of the TEHDI program utilizing system data to manage the program.				X
3. Activity 3: Collaborate with multiple stakeholders to develop and disseminate educational materials for providers and parents.				X
4. Activity 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 Certification process was reinstated in October 2012 via an email announcement using the distribution list of Licensed Birthing Facilities. Two teleconference calls were conducted in November 2012 to provide facilities with new information regarding the certification process. A total of 83 facilities are scheduled for certification in July 2013. Another 111 facilities are scheduled for January 2014.

Activity 2: A total of 187,493 infants born in facilities needed a newborn hearing screen. Of those newborns, 98% (184,538) received a hearing screen before discharge. Of those screened, 98% (180,289) passed the screening. A total of 3% (5,660) newborns required follow-up before discharge, which includes 1% (1,411) of newborns who missed the screening and 2% (4,249) of newborns who did not pass the birth screen.

Activity 3: A total of 335,232 materials were distributed to parents and non-state providers. TEHDI staff exhibited materials at the Texas Academy of Audiology conference held in November 2012. There were 332 Open Records Requests from non-state agencies during this reporting period.

Activity 4: A total of 72 providers completed DSHS Newborn Hearing Screening trainings. One medical home outreach education activity was provided to 10 participants. The TEHDI Program and TEHDI data contractor continued a monthly postcard notification to all primary care providers who have patients that need follow up care.

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: Evaluate the TEHDI program utilizing system data to manage the program.

Output Measure(s): Number and percent of infants screened before hospital discharge; 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: Develop and disseminate educational materials for stakeholders.

Output Measure(s): Number of activities and materials developed and disseminated; number and type of stakeholder events attended.

Monitoring: Documentation of activities and educational events attended including educational materials distributed.

Activity 4: Provide training, outreach, and technical assistance to Licensed Birthing Facilities and providers.

Output Measure(s): Type and number of trainings delivered; number of new 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; review THSteps CE module completion records.

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	2008	2009	2010	2011	2012
Annual Performance Objective	20	20	19.5	17	14
Annual Indicator	17.9	16.3	16.3	15.4	14.6
Numerator	1216968	1133117	1152738	1059874	1007822
Denominator	6783441	6966193	7072725	6882300	6902892
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
	2013	2014	2015	2016	2017
Annual Performance Objective	14	13.7	13.7	13.7	13.7

Notes - 2012

2011 data were taken from the 2012 Current Population Survey administered by the Census Bureau. The 2012 is a linear estimate using the 2008-2011 data.

Notes - 2011

2011 data were taken from the 2012 Current Population Survey administer by the Census Bureau.

Notes - 2010

Update: 2010 data is now based on the Census data.

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

a. Last Year's Accomplishments

Activity 1: The 2011 American Community Survey estimates 1,007,809 (14.7%) of the 6,864,205 children under the age of 18 residing in Texas do not have health coverage.

Activity 2: In FY12, Title V funded contractors screened 36,407 individuals for Medicaid, CHIP, and other insurance. Contractors provided limited prenatal care to 2,976, child health services to 18,996, and basic child dental care to 14,435 who had no other coverage at the time they were seen. Contractors were required to make appropriate referrals and support clients in applying for coverage if available.

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 approximately 3,800 referrals to CHIP or children's Medicaid services, and over 800 referrals to DSHS Title V Child Health/Dental Contractors.

Performance Assessment: Data indicates that the percent of children without health insurance declined from FY11 to FY12. This is due, in part, to Title V policy that contractors work to link families to Medicaid and/or CHIP or other health coverage to the extent available. With full implementation of the Affordable Care Act (ACA) in January 2014, more children will have access to healthcare coverage decreasing the number of children without health insurance. Title V staff remain ready to review and adapt programs as needed ensuring all children have needed coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Monitor and report the percentage of children without health insurance.				X
2. Activity 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		
3. Activity 3: Identify and develop partnerships with internal and external stakeholders to increase children's access to insurance.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: There are no updates for this activity until the end of FY13 as estimates are developed for calendar years from various sources.

Activity 2: Excluding those served by CSHCN SP contractors, there were 19,868 individuals under the age of 21 served by Title V-funded contractors throughout the state. Of those, 1,230 received prenatal care, 10,444 in the child health services, and 8,194 in the child dental.

Activity 3: DSHS regional staff provided information and referrals for families of children accessing services through DSHS-funded clinics to improve access to insurance through participation in health fairs and other activities. DSHS staff assisted families whose children were uninsured or underinsured with more than 1,500 referrals to CHIP/Medicaid services and approximately 500 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 (including the new CHIP perinatal benefit) 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 Services 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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	21	23	29	31	33
Annual Indicator	31.5	31.4	34.7	35.7	32.7
Numerator	146631	140676	171101	177273	177996
Denominator	465319	448039	492775	496167	543569
Data Source	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	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	32	31	30	30	30

Notes - 2012

Data provided by the Texas WIC program

Notes - 2011

Data provided by Texas WIC program

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.

a. Last Year's Accomplishments

Activity 1: In FY12, 440,517 of the 484,157 WIC enrolled women (91%) received nutrition education and 1,215,522 (86.5%) of the 1,405,419 total WIC population (women and children) enrolled received nutrition education.

A total of 37 local WIC agencies involved in the Obesity Prevention Mini Grant program held activities such as healthy cooking demos, creating community gardens, and promoting physical activity. Over 66% of the target audience for the projects was WIC families.

Activity 2: Staff administered the biennial 2011 WIC Infant Feeding Practices Survey from September to November 2011. More than 12,000 surveys were distributed to over 450 WIC clinics across the state for mothers of infants ages 3 months to 1 year of age that received WIC services during pregnancy. A total of 10,864 completed surveys were received with 7,233 in English and 3,631 in Spanish. Staff performed an analysis of the data and developed a data code book in FY12. The report, examining state, regional and local WIC agency data findings, will be completed by the end of FY13.

Results of tracking fruit and vegetable purchases of WIC participants indicated the top purchased produce to be 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 developed 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. As of November 2011, the state population potentially eligible for Texas WIC services was 74.9%.

Performance Assessment: The percentage of children with a BMI at or above the 85th percentile who receive WIC services decreased from 2011. Efforts at the state and local level to address childhood obesity included but were not limited to implementing local obesity prevention activities via mini-grants, breastfeeding media efforts, and WIC food package changes. Exploring further opportunities to provide education and encourage breastfeeding as part of other DSHS projects and initiatives may contribute to further reductions in childhood obesity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.			X	
2. Activity 2: Support activities that address food consumption patterns in WIC families.				X
3. Activity 3: Identify factors that affect the redemption rate for WIC participants and the length of time participants remain on the WIC program.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: To date, 322,208 of the 367,337 WIC enrolled women (87.7%) received nutrition education and 770,423 (74.8%) of the 1,029,869 total WIC population (women and children) enrolled received nutrition education.

A total of 34 local WIC agencies involved in Obesity Prevention Mini Grants held activities such as healthy cooking demos, creating community gardens, and promoting physical activity. More than 66% of the audience included WIC families.

Activity 2: Tracking fruit and vegetable purchases of WIC participants indicated participant's preference for bananas, tomatoes, grapes, avocados and onions. Bananas were consistently a top pick while apples or Iceberg lettuce were a distant sixth. Trends in milk type (2%, 1%, Fat-free) indicated a preference for 2% (94%). Despite extensive nutrition education, whole milk still accounted for 20% of all milk purchases.

Initial analyses of state and regional data from the 2011 WIC Infant Feeding Practices (IFPS) survey were completed. Analyses of WIC local agency data are underway. A highlight report and the 2013 WIC Infant Feeding Practices Survey are in development.

Activity 3: Local WIC agencies developed outreach plans to ensure potentially eligible persons are aware of WIC and know where to seek services. Activities included distribution of information about WIC to agencies and individuals that serve or work with potentially eligible persons. The state population potentially eligible for Texas WIC services is 68.2%.

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 provided; fund WIC obesity projects; fund 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; review reports and present 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; track percentage of potentially eligible participants served 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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	7.5	8	8	6.9	6
Annual Indicator	6.0	8.3	7.0	3.5	3.0
Numerator	24517	35188	26925	12867	11777
Denominator	405242	425467	385746	370363	388384
Data Source	PRAMS and Natality Data	Natality File			
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
	2013	2014	2015	2016	2017
Annual Performance Objective	3	3	2.8	2.8	2.7

Notes - 2012

Data are based on the percentage of births where it was indicated on the birth certificate that the mother smoked in the third trimester of pregnancy. The denominator is the number of live births

where this information is not missing on the birth certificate. The 2012 birth file is preliminary and subject to change.

Notes - 2011

Final PRAMS dataset for 2011. Texas did not meet the response rate cut-off for generalizability in 2011, so the data should be viewed with caution. The denominator is the total weighted sample for PRAMS.

Notes - 2010

Update: The PRAMS and birth data for 2010 are final.

a. Last Year's Accomplishments

Activity 1: The Centers for Disease Control and Prevention conducted an intensive 12-week media campaign from March through June 2012 resulting in a 340% increase in calls to the Quitline and a 337% increase in enrollment in cessation services as compared to the two weeks prior to the media campaign implementation.

There were 13,926 calls to the Quitline, 9,319 people enrolled in counseling, 4,888 received nicotine replacement therapy, and 1,032 people enrolled in the online web-coach services. Of those who called the Quitline during calendar year (CY) 2011, 60.38% were women. Of women callers, 1.86% were pregnant at the time they called the Quitline, 1.20% were planning to become pregnant in the next three months, and less than 1% were actively breastfeeding at the time of their call.

The tobacco cessation campaign, Quit for Your Child, ran from July 9 through August 31 and was funded partially by Title V. It featured a website designed for traditional and mobile viewing, on-line banners for traditional and mobile websites, and push text messages. Radio and television messages ran in the Austin, San Antonio, Fort Bend, Lubbock and Tyler markets where comprehensive tobacco coalitions are in place. These messages complemented television messaging for women created in FY11 with Title V funding. All media targeted women ages 18-34. The media campaign reached 1,439,790 people with 19,694,981 cessation message impressions designed for women and mothers.

One of the highlights of this campaign was the level of traffic to the website, www.quitforyourchild.org. In the first eight weeks that the website was active, it had 49,138 unique visits, which is 415% more than the primary cessation website, www.yesquit.org, had in all of FY12. In addition, 96% of the site visits were directly related to the media buys during that time.

The media was designed to encourage women who use tobacco and are pregnant or have small children to make a change in their tobacco use behaviors by contacting the Texas telephone cessation Quitline. During the media flight months, 857 women contacted the Quitline, accounting for 61.4% of all tobacco users contacting the Quitline. In addition, 95 women accessed the web-only resources, accounting for 69.9% of tobacco users utilizing the online web coaching option. Of these women, 31 were currently pregnant, 17 were planning on becoming pregnant, and six were currently breastfeeding. Approximately 35.2% of the women who had contacted Quitline lived within the service area of one of the comprehensive coalitions.

DSHS regional staff participated in community activities related to tobacco prevention and cessation for pregnant women, including participating in Great American Smoke Out activities, health fairs, providing presentations at WIC clinics, perinatal education programs, programs for refugees, developing training for community health workers, and distributing prevention and cessation materials.

Activity 2: According to PRAMS data, the estimated percent of women who reported smoking during the last three months of pregnancy in 2011 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 (CHW) was certified by the DSHS Community Health Worker Training and Certification Program. The training was delivered at the Community Health Workers Across Texas: Working Together for Healthy Texas Babies conference in August 2012 attracting over 300 CHWs and promotores from across the state.

Performance Assessment: Data indicated that overall smoking rates are decreasing. However, smoking rates in the last three months of pregnancy for White women ages 13 -19 continue to remain much higher than Blacks or Hispanics. Continued education and treatment remain priorities for Title V and the tobacco cessation program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Support statewide tobacco prevention and cessation efforts that target men and women of childbearing age and their families.			X	
2. Activity 2: Monitor smoking rates in the last three months of pregnancy among adults and teens by race and ethnicity.				X
3. Activity 3: Develop, implement, promote, and evaluate 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: During this time period, 2,017 women called the Texas Quitline. Of those, 62 were currently pregnant, 28 were planning to become pregnant within three months of calling, and seven were currently breastfeeding. Due to contract implementation delays, the media flight in November 2012 for cessation media was limited. DSHS updated their cessation website, www.yesquit.org, to include a 30-minute clinician training on cessation now approved for continuing education for physicians, nurses, social workers, counselors, and health educators. DSHS funded comprehensive coalitions continued to promote tobacco prevention and cessation activities within their communities.

Activity 2: DSHS anticipates having data to report on this measure by the end summer 2013 as data from BRFSS and PRAMS is not yet available. Data from YRBS is inclusive only of high school students and does not include information about their smoking habits related to pregnancy status.

Activity 3: The curriculum developed by a certified community health worker instructor was made available to other approved CHW training programs for continuing education units for CHWs.

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, including collaborative efforts with Medicaid and CHIP.

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: Review reports of media campaigns funded by DSHS; review information on other media campaigns not funded by DSHS (as available); number of monthly calls by men and women to Quitline during DSHS purchased media flights.

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: Promote smoking cessation among pregnant women through DSHS-driven media.

Output Measure(s): Cross-promotion of tools available through Texas Tobacco Prevention and Control on SomedayStartsNow.com; integration of yesquit.org materials for providers on provider section of SomedayStartsNow.com and HealthyTexasBabies.org; integration of Texas Tobacco Prevention and Control materials into outreach implementation packets to promote Someday Starts Now.

Monitoring: Survey of SomedayStartsNow.com and HealthyTexasBabies.org for integrated messaging on smoking cessation for pregnant women and providers; inclusion of smoking cessation resources for pregnant women in Someday Starts Now promotional packets for outreach partners available for order through DSHS warehouse.

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	2008	2009	2010	2011	2012
Annual Performance Objective	6	5.5	5.2	7.5	7.4
Annual Indicator	7.2	8.7	7.5	8.0	8.5
Numerator	134	163	142	155	159
Denominator	1866100	1882929	1883124	1927596	1869019
Data Source	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?				Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	8	8	7.8	7.8	7.5

Notes - 2012

The 2012 death file is preliminary and subject to change. The denominator is from the Texas Data Center from the Office of the State Demographer.

Notes - 2011

The 2011 data are from the provisional 2011 death file. This file will be finalized in August 2013. The denominator is a population estimate by the Office of the State Demographer.

Notes - 2010

June 2012: Mortality data for 2010 are now final.

Denominator is 2010 Census data.

a. Last Year's Accomplishments

Activity 1: In FY12, DSHS distributed 489,691 printed materials. The Best Practice list for suicide prevention (SP) for schools was added to the DSHS website. The ASK (Ask about suicide, Seek more information, Know how and where to refer) SP smart phone app had 11,180 downloads. A total of 49 SP exhibits were conducted. An e-newsletter was sent to 2,487 recipients and posted on the website for general access. The annual SP Symposium was publicized through the website, listserv, e-newsletter and at meetings. Seventeen SP Symposium handouts and PowerPoint presentations were posted on <http://www.texassuicideprevention.org/information-library/symposium-presentations>.

Activity 2: More than 5,900 individuals were trained through 178 QPR (Question, Persuade, and

Refer) and ASK gatekeeper trainings and 155 individuals became ASK instructors. DSHS approved ASK training for continuing education for community health workers. In FY12, 3,763 high school educators enrolled in the Kognito online SP training. Fifteen colleges partnered for the College Student and Faculty At-Risk online training, with 419 students and 376 faculty members participating in the training. Nearly 600 individuals received information on SP through presentations, workshops and trainings through the Texas School Health Network project. The annual SP Symposium was attended by 875 individuals. A pre-symposium extended session, "Military and Vets: Overview of State and Federal Public Services, and Brief Cognitive Therapy for Service Members," had 410 attendees and a post-symposium extended session on "Supporting the Suicide Bereaved: Lessons Learned from Peer Helpers" had 202 attendees. A session, "Making Connections: Suicide Prevention Training through Movement," was held with 48 University of Texas students and faculty in attendance, and a later train-the-trainer session on this prevention tactic was attended by eight individuals. Applied Suicide Intervention Skills Training (ASIST) was delivered to 33 attendees, and two ASIST train-the-trainer sessions prepared 48 new trainers. A Multicultural Suicide Prevention: Saving Lives in our Diverse Communities training had 35 attendees. SP training was presented at the Texas Injury and Violence Prevention Conference with 150 attendees. DSHS regional staff in Polk County made weekly SP presentations to teens involved with juvenile probation. DSHS regional staff informed Child Fatality Review Teams (CFRTs), school districts, and School Health Advisory Councils (SHACs) about resources related to bullying prevention. DSHS staff conducted training using the QPR and ASK SP curricula for nurses, community health workers, and others.

Activity 3: The Suicide Prevention Council held their annual meeting during the SP symposium, The Council presented their annual report the Youth Suicide Prevention Program. Consultations on SP and postvention were made with eight SP coalitions: Brazoria County, Mental Health America Houston, UT Austin, Tarrant County, Southeast Texas, Highland Lakes, Midland, and West Texas. Planning began for a new coalition through the Crisis Help Line of Dallas. Six consultations with community groups, including Texas Association of School Age Parenting and the National Organization for People of Color Against Suicide, were held. DSHS regional staff participated in local or regional SP coalitions across the state, including Texas Panhandle, South Plains, I AM HERE, Save a Life Today (SALT), Austin/Travis County, Bastrop County, and Highland Lakes SP Coalitions. DSHS staff shared data and information on bullying and SP and participated in activities or planning related to SP at 280 meetings.

Activity 4: CFRTs reviewed 97 suicide deaths, with 69 of those deaths of youth 15-17 years old. Members of 3 East Texas CFRTs helped form the SALT coalition that covers 12 east Texas counties. They participated in the SALT SP walk, where 125 individuals walked and raised \$2,500 for SP. Statewide, CFRT members were informed of multiple webinars on bullying and SP prevention, and many participated and shared the information with others in their communities. Taylor County CFRT made plans to host a SP gatekeeper training in Abilene.

Performance Assessment: Suicide rates age 15 through 19 have been fairly stable over the last few years. Access to evidence-based resources and training to youths from young ages to the teen years help prevent more suicides in this age group.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Broaden the public's awareness of youth suicide, its risk factors, and prevention.			X	X
2. Activity 2: Provide training to individuals, communities, and schools to identify and refer youth at higher risk of suicide and suicide attempts.				X
3. Activity 3: Provide support to internal and external stakeholders addressing suicide prevention.			X	X

4. Activity 4: Report on suicide deaths of 15-17 year olds and CFRT activities to promote suicide prevention.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Over 512,000 SP (suicide prevention) print materials were distributed. There were 60 SP exhibits displayed. Website redesign for mobile access continued. Online app for ASK (Ask about Suicide, Seek more Information, Know How and When to Refer) training had 17,894 downloads.

Activity 2: There were 239 QPR (Question, Persuade and Refer) and ASK trainings with 7,713 individuals trained. ASK instructor training was provided 11 times with 267 instructors trained. DSHS approved ASK curriculum for community health worker training. Online gatekeeper training at 15 colleges reached 789 faculty and 582 students.

Activity 3: Consultations were provided to 14 SP coalitions and 15 community groups. To date, 6,848 high school educators and 1,712 middle school educators have enrolled in online training. The YouTube site has 17 videos viewed 75,924 times. A new Spanish PSA musical video was produced and shown on Austin Univision station at no cost. DSHS regional staff participated in eight SP coalitions and provided CFRTs and school districts information and resources on bullying. They conducted training using QPR or ASK for nurses and community health workers. Regional staff participated in SP activities at 200 meetings.

Activity 4: Multiple CFRTs served on suicide coalitions. One CFRT began work on a SP campaign with a rural county health coalition. CFRTs completed retrospective reviews of 59 child suicide deaths from 2010.

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; track the number of "hits" to the website; 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 trainings provided; 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);, number of middle and high schools that have access to "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: Document suicide prevention best practice trainings completed.

Activity 3: Provide support to internal and external stakeholders addressing suicide prevention.

Output Measure(s): Participation in the Texas Suicide Prevention Council; ongoing maintenance of information about the Suicide Prevention Coalitions established statewide; number of regional activities; documentation of presentations on suicide prevention.

Monitoring: Summarize activities of 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 Regions staff reports for activities pertaining to suicide prevention; track suicide prevention presentations.

Activity 4: Report on suicide deaths of 15-17 year olds and CFRT activities to promote suicide prevention.

Output Measure(s): Development of public awareness/educational materials; review of suicide deaths of youth 17 and younger as reported in the State Child Fatality Review Team (CFRT) Committee annual report; number of trainings on developing suicide prevention initiatives presented to CFRTs; 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; track local CFRT training; document 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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	52	52	52	50	50
Annual Indicator	50.2	50.1	49.8	48.2	45.6
Numerator	2946	2967	2810	2631	2595
Denominator	5865	5920	5641	5455	5691
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	Provisional

Final?					
	2013	2014	2015	2016	2017
Annual Performance Objective	50	50	52	52	52

Notes - 2012

The 2012 Survey of Hospitals was not complete by the time of the report. The list of High Risk Delivery Hospitals is based on the 2011 Survey of Hospitals. The 2012 birth file is preliminary and subject to change.

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.

a. Last Year's Accomplishments

Activity 1: A HTB workgroup, Maternal Transport Committee, began operationalizing Expert Panel (HTB-EP) recommendations for maternal transport algorithms to facilitate prenatal transfer of high-risk mothers to the appropriate level of care for delivery of Very Low Birth Weight infants. Staff reviewed and discussed existing state models. The workgroup established goals met bi-weekly to develop algorithms for common maternal/fetal conditions necessitating transfer including preterm labor, placental problems, and hypertension, and developed a model for establishing agreements between community and anchor facilities. Members for the HHSC Neonatal Intensive Care Unit (NICU) Council held meetings to develop recommendations for operating standards, improvements and changes to Medicaid NICU care reimbursement. DSHS worked with the NICU Council to gather survey information on NICU and obstetrics quality of care services.

Activity 2: Questionnaires assessing Texas birthing facilities with self-designated levels of care and facility capacity for perinatal and neonatal care were developed in coordination with HHSC. Each birthing facility in Texas received an electronic questionnaire. The final response rates were 70.1% for the neonatal survey and 71.3% for the perinatal/obstetric survey. Findings were presented to the NICU Council in September 2012.

Activity 3: In 2012, there were 5,691 very low birth weight (VLBW) babies born in Texas to state residents. Of these, 45.6% (n=2,595) were born in a Level III hospital, a designation based on the AHA self-designated obstetric level.

Performance Assessment: Data indicated a continued decline in the annual indicator. However, birth data are preliminary and 2012 hospital designation data are not yet available, so data are subject to change. DSHS remains committed to supporting implementation of promising strategies associated with HTB and the NICU Council as well as to exploring new options for improvement toward this measure.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Activity 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. Activity 2: Update map of level III neonatal intensive care unit (NICU) hospitals in Texas and develop a promotion and distribution plan for sharing with partners.				X
3. Activity 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: The HHSC Medicaid Neonatal Intensive Care Unit (NICU) Council continued to meet studying and making recommendations regarding NICU operating standards and reimbursement payment through the Medicaid program for services provided to an infant admitted to a NICU. Three subcommittees (NICU Standards, Maternity Standards, and Best Practices) met regularly by teleconference. The HTB Maternal Transport Committee convened regularly to develop draft maternal transport algorithm and transfer agreements. These were submitted to the HTB Expert Panel for review. HB 15, 83rd Regular Session, relating to level of care designations for hospital neonatal and maternal care passed and was signed into law by Governor Perry.

Activity 2: A Report of the 2012 Neonatal/Obstetric Level of Care Survey, designed to assess facility consistency with self-designated levels of care and capacity for perinatal and neonatal care, was released and findings were presented at the September NICU Council meeting. Final response rates were 70.1% for the neonatal survey and 71.3% for the perinatal/obstetric survey. While 79 of responding facilities self-reported being Level III NICUs, only 15 were classified as Level III as defined by an AAP-Based Algorithm.

Activity 3: According to preliminary 2012 birth data, 5,691 very low birth weight babies were born in Texas to state residents. Of these, 45.6% (n=2,595) were born in level III hospitals. Level is based on 2011 AHA self-designated obstetric level.

An attachment is included in this section. IVC_NPM17_Current Activities

c. Plan for the Coming Year

Activity 1: Partner 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: Work with partners and health care systems to increase the proportion of birthing facilities in Texas with neonatal intensive care unit (NICU) designation levels that are consistent with recommended criteria for levels of care.

Output Measure(s): Number and types of activities to increase the proportion of birthing facilities that meet or exceed recommend criteria for their designated levels of care.

Monitoring: Document activities and impact.

Activity 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.

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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	73	74	66	58	64
Annual Indicator	57.9	54.9	56.9	59.4	62.1
Numerator	234829	220473	219333	223994	242148
Denominator	405242	401599	385746	377124	389901
Data Source	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?				Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	65	65	65	65	65

Notes - 2012

Data are from the 2012 preliminary birth file and subject to change.

Notes - 2011

2011 data are based on a provisional birth file from the Center for Health Statistics.

Notes - 2010

Update: 2010 data is final.

a. Last Year's Accomplishments

Activity 1: The Healthy Texas Babies (HTB) initiative continued placing emphasis on early prenatal care through the launch of the HTB website, www.healthytexasbabies.org. The website was designed for multiple users including mothers and fathers-to-be, their friends, family and employers, and women's health providers. The site, available in English and Spanish, provided valuable information about accessing health insurance during pregnancy, links to interactive web

tools and others resources for parents-to-be. DSHS started planning the Someday Starts Now campaign in late summer 2012 to include a robust website, a series of TV and radio PSAs and tools for parents and parents-to-be to enhance communication, and shared decision-making with their providers.

Activity 2: DSHS regional staff partnered with community coalitions, March of Dimes chapters, FQHCs, hospitals, and other providers and community groups to provide information and materials aimed at improving prenatal care outcomes and increasing access to care for pregnant women. DSHS regional clinic staff provided referrals for pregnant women to CHIP Perinatal or Medicaid for pregnant women (over 1,800), Title V prenatal contractors (over 550) and Women's Health Program (over 1,700).

According to 2010 PRAMS data, the most recent data available, 74.6% of women reported receiving prenatal care beginning in the first trimester while 78.7% of women reported receiving prenatal care as early as they wanted.

According to Texas birth certificate data September through December 2011, which is the most recent birth data available for FY12 at the time of reporting, there were 129,190 births in Texas and 63.8% of women began prenatal care (PNC) in the first trimester. 61.3% of women received at least adequate PNC based on the Adequacy of Prenatal Care Index.

Activity 3: DSHS continued its focus in pre- and inter-conception care. Efforts included development of a multi-disciplinary, interagency committee to create a life planning tool for young people to use to set life goals and plan their reproductive years. In addition, development of an inter-conception web lesson, in collaboration with the March of Dimes, for use among WIC program participants in the post-partum period. The lesson discussed inter-conception health such as folic acid supplementation, diet and exercise, birth spacing and other topics.

Four of the ten HTB-funded coalitions are doing pre- and inter-conception projects using evidence-based models from other states. The Harris County Women with IMPACT initiative provided pre- and inter-conception classes and a supportive network of women in Houston's African American community. The Corpus Christi-Nueces County Public Health Department identified pre-conception diabetic conditions among Hispanic women of childbearing age and referred to them treatment and nutrition education. The Centering Program in Gregg County provided group prenatal care with special emphasis on enrolling women with previous poor birth outcomes, which has been shown to increase a woman's chances of keeping all her prenatal appointments. The San Antonio HOPES Project provided intensive home visiting by a nurse and social worker for women at high-risk of a subsequent preterm delivery.

Formative research indicated that pre-conception health promotion was the most effective way to target the leading causes of infant mortality in Texas. Planning began in the summer to develop a multimedia public awareness and education campaign. The campaign, Someday Starts Now, slated for release in the fall of 2012, will focus on the importance of healthy living on planning to have a baby and before one plans to have a baby.

Performance Assessment: Prenatal care efforts continue to be at the forefront for DSHS with the Healthy Texas Babies initiative. Coalitions funded through the HTB initiative along with regional staff and Title V contractors work to provide education, supports, and linkages to care with Medicaid and CHIP. Referrals increased in FY12 documenting the importance of prenatal care. Educational outreach planned for FY13 will expand on these efforts highlighting prenatal care along with healthy living in the upcoming Someday Starts Now campaign.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. Activity 1: Increase infrastructure for improving access to prenatal care.	X		X	X
2. Activity 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. Activity 3: Increase DSHS engagement in preconception and interconception health.				X
4.				
5.				
6.				
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9.				
10.				

b. Current Activities

Activity 1: Title V MCH Fee for Service Contractors served 6,122 prenatal/postpartum clients. There were 702 referrals by DSHS regional staff to CHIP Perinatal and Medicaid for pregnant women as well as 199 referrals to Title V Prenatal contractors by DSHS regional staff and 816 referrals to the Texas Women's Health Program.

Activity 2: DSHS anticipates having data on the percent of infants born to women who received early and adequate prenatal care available from PRAMS and the birth record by Summer 2013.

Activity 3: In September, 89 students completed the Office of Minority Health Preconception Peer Educator (PPE) training program at Prairie View A&M University. DSHS launched Someday Starts Now, the bilingual Healthy Texas Babies public awareness campaign. The website www.somedaystartsnow.com in English and www.algundiaempiezaahora.com in Spanish features a Life Planning Tool to assist women with pre- and inter-conception health maintenance. During the first three weeks of the campaign, the websites had 54,415 unique visitors and over 8,000 visitors downloaded the Life Planning Tool. The campaign launch included presentations at conferences, a 12-stop college campus outreach tour, outreach to 300 beauty and barber shops in Dallas, Fort Worth and Houston, and a Hispanic community event in San Antonio. The campaign was broadcast through a series of TV and radio public service announcements, online banner ads and through online search tools.

An attachment is included in this section. IVC_NPM18_Current Activities

c. Plan for the Coming Year

Activity 1: Promote access to first-trimester prenatal care through DSHS-driven media.

Output Measure(s): Number and type of educational sessions for providers and their scheduling staff on early-entry into prenatal care; availability of information on HealthyTexasBabies.org and SomedayStartsNow.com on the importance of first-trimester prenatal care for patients; inclusion of prenatal care access information in promotional packets for outreach partners.

Monitoring: Document number and type of educational sessions; track requests for outreach partner promotional packets available for order from DSHS to promote first-trimester prenatal care.

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 inter-conception health.

Output Measure(s): Number of partners and initiatives DSHS participates in pertaining to preconception and inter-conception health.

Monitoring: Document efforts with partners and document initiatives DSHS is involved with pertaining to preconception and inter-conception 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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	90	85	85	80	80
Annual Indicator	100.4	97.8	97.0	94.6	89.2
Numerator	1624	1582	1568	1530	1442
Denominator	1617	1617	1617	1617	1617
Data Source	Permanency Planning and Family Based Alt. Report				
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	80	80	80	80	80

Notes - 2012

Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- July 2012 (covers March 1, 2012 to August 31, 2012)

The FY12 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 for Individuals with an Intellectual Disability or Related Conditions decreased slightly, there was an increase in the number of children in Home and Community-Based Service facilities.

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.

a. Last Year's Accomplishments

Activity 1: CSHCN SP regional staff and contractors assisted 1,959 CYSHCN and their families with permanency planning activities. The HHSC Senate Bill (SB) 368 Permanency Planning Report noted that 1,442 children resided in institutions for the six-month period ending August 31, 2012, including 551 children recommended for transition to the community. During the reporting period, 119 children moved to family-based settings and 158 children moved to other less restrictive environments.

EveryChild, Inc. shared findings from a previously funded Title V study with various forums as input to recommendations for system improvements towards keeping more children living in families.

Activity 2: CSHCN SP contractors and health care benefits provided family support services to 2,091 children and families and 96,781 respite hours. CSHCN SP provided a health care benefit for 2,019 children.

Contractors expanded respite to serve more families and collaborated with local organizations helping families access needed services to maintain and stabilize housing. DSHS contractor, SHARE, provided respite for parents attending a genetics conference and created opportunities for youth with disabilities to work as volunteers on respite nights. SHARE implemented free in-home respite care by nurses for families of CYSHCN who otherwise have no access to respite. Staff from the Children's Special Needs Network (CSNN), a CSHCN SP contractor, met with Kathy Greenlee, Administrator, Administration for Community Living and Assistant Secretary for Aging, to model future initiatives after the work of CSNN and other partners to support families.

Staff distributed information to contractors and regional staff on public funds available for ramps and other modifications to support children living at home. Additionally, the CSHCN SP Family Newsletter featured an article on the availability of one-time grants for home modifications necessary for accessibility.

The Take Time Texas (TTT) website formally launched and included the Texas Inventory of Respite services database featuring non-profit, governmental, faith-based, and local options for respite. Staff participated in site development activities, contributed educational resource materials, and hosted a TTT presentation to contractors.

Activity 3: CSHCN SP staff worked with groups including the Texas Respite Coalition, Consumer Direction Services Workgroup (CDWG), Children's Policy Council, Achieving Successful Systems Enriching Texas (ASSET) Steering Committee on efforts to keep children living at home in families.

Staff collaborated with family members of the CDWG and other stakeholders to address serious accessibility and other issues in an electronic verification system designed to track direct support workers. Efforts led to policy changes to ease requirements and add flexibility for individuals using consumer directed services.

The Youth Empowerment Services (YES) Waiver, which provides intensive community-based services to children with serious emotional disturbance and their families, expanded to the Dallas area. Staff provided input to ASSET's planning grant team and the statewide strategic plan for System of Care expansion to improve services for children with mental health diagnoses.

Staff monitored STAR+PLUS managed care expansion activities and facilitated conference calls with HHSC Medicaid managed care staff to keep contractors informed. STAR + PLUS combines acute care with community-based long-term services and supports such as help with daily activities, home modifications, personal assistance, and respite.

Texas applied for federal funds for the Balancing Incentive Program to increase access to Medicaid community-based, long-term services and support and a related program to expand the state's network of Aging and Disability Resource Centers.

Performance Assessment: Residential settings continued a shift to smaller, less restrictive environments in FY12. Staff efforts, supported by community-based contractors, continued addressing barriers, such as inadequate community supports, medical services, attendant care, behavioral intervention, and lack of respite. By providing education to stakeholders and promoting less restrictive environments, the number of children residing in institutions decreased over 5% from the previous year. Efforts continue to ensure more CYSHCN continue living with their families in their communities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.		X		
2. Activity 2: Fund and promote respite and other family support services through contracts, CSHCN SP health care benefits, and collaboration with other entities.		X		
3. Activity 3: Collaborate with public and private entities to foster permanency planning, natural supports, 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 903 CYSHCN and their families with permanency planning activities.

Activity 2: CSHCN SP contractors and health care benefits provided respite and other family support services to 1,042 children and families totaling 31,450 respite hours. Contractors continued providing vital supports to families which included funding for basic needs and medical expenses not otherwise covered, and essential supplies to help ensure CYSHCN live at home in the community.

Activity 3: CSHCN SP staff continued active involvement in numerous workgroups including the Texas Respite Coalition, Consumer Direction Services Workgroup, Children's Policy Council, and Achieving Successful Systems Enriching Texas (ASSET) Steering Committee to improve policies and programs preventing institutionalization and supporting children living in families. Staff shared information on funding resources for home modifications with contractors and regional staff.

Texas was awarded federal funds for the Balancing Incentive Program to increase access to Medicaid community-based, long-term services and supports by implementing a "no wrong door" single-point of entry for services, conflict-free case management, and a core standardized assessment tool.

The YES waiver, which provides intensive community-based services and supports for CYSHCN with serious emotional disturbances and their families, announced plans to expand to Harris County in the Fall of 2013.

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; 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 regional activity and contractor quarterly reports; data from the HHSC Permanency Planning and Family-Based Alternatives 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 contractors; number of CYSHCN provided respite and other family support services through contractors and health care benefits; number of total respite hours provided by contractors and health care benefits.

Monitoring: Review 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 CYSHCN 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; 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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				1.5	1.5
Annual Indicator	1.6	1.5	1.8	1.6	1.7
Numerator					
Denominator					
Data Source	Nativity and Mortality Data				
Is the Data Provisional or Final?				Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	1.4	1.4	1.3	1.3	1.3

Notes - 2012

Fetal death information is not yet available for 2012. The rate for 2012 is estimated using the linear trend line estimated based on the 2008-2011 data.

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)

Nativity, 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 are 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.

a. Last Year's Accomplishments

Activity 1: Texas reported 2,990 fetoinfant deaths in 2010, for a rate of 7.7 fetoinfant deaths per 1,000 fetal deaths/live births, including 710 estimated to be excess fetoinfant deaths, for a rate of 1.8. Linear trends estimated 3,000 fetoinfant deaths in Texas in 2011, for a rate of 7.5 fetoinfant deaths per 1,000 fetal deaths/live births, including 648 estimated to be excess fetoinfant deaths, for a death rate of 1.7.

Activity 2: DSHS conducted secondary analyses 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 three 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: Staff drafted summary analyses reports and provided reports to select local communities to use to develop responses to a Healthy Texas Babies (HTB) Request for Applications. Texas funded community coalitions in 11 counties of the state with the highest Medicaid populations, highest rates of prematurity, more than 1,000 births per year and large populations of African American families to develop and implement activities aimed at addressing needs identified through the PPOR analyses.

DSHS announced the availability of reports to the HTB Expert Panel and reports were posted to the HTB website: <http://www.dshs.state.tx.us/healthytebabies/data.aspx>.

Activity 4: Staff coordinated and participated in infant health workgroups, committees, partnerships, and trainings. A Healthy Texas Babies (HTB) Workgroup was formed to operationalize HTB Expert Panel (HTB-EP) recommendations. Two HTB-EP meetings were held to facilitate consultation on HTB activities and to begin to develop a sustainable infrastructure for HTB governance. A HTB Strategic Plan was drafted.

Committees were formed to develop implementation strategies and tools in six topic areas. Committees convened to develop tools and resources for dissemination to providers, families, and communities.

Eleven selected applicants were funded to develop HTB coalitions to implement evidence-based interventions to address infant health outcomes in 11 counties of the state. Coalition activities are summarized on the HTB website's coalition page:

<http://www.dshs.state.tx.us/healthytebabies/coalitions.aspx>

A committee was developed to plan a Preconception Peer Educator (PPE) Program Training in partnership with the Office of Minority Health. The training will be piloted at Prairie View A&M, a historically black university, in September 2012.

DSHS disseminated information about text4baby to partners via weekly newsletters. A fact sheet summarizing CY2011 enrollment was developed and posted on the HTB website:

<http://www.dshs.state.tx.us/healthytebabies/text4baby.aspx>

Work on a media campaign, Someday Starts Now, began in July. The campaign will include information for women, men, parents, providers, and stakeholders.

HHSC convened a Medicaid Neonatal Intensive Care Unit Council, created by House Bill 2636 during the 82nd Legislative Session to make recommendations to HHSC on NICU standards and reimbursement through the Medicaid program.

FY12 activities related to reduction of non-medically indicated deliveries prior to 39-weeks included the Medicaid rule changes to eliminate reimbursement of non-indicated pre-39 week deliveries and an online Continuing Education module about preventing elective deliveries prior to 39 weeks was developed for the THSteps provider education portal.

Performance Assessment: The rate of excess fetoinfant mortality was identified using PPO mapping, and is estimated, based on linear trend, to be 1.7 excess fetoinfant deaths per 1,000 fetal deaths/live births for 2012. With minor fluctuations in either direction year-over-year, the rate remains essentially unchanged. Secondary analyses facilitated identification of community-specific priorities. Resources were allocated to support community capacity development and implementation of strategies to target excess fetoinfant mortality and maternal-infant health disparities across the state.

An attachment is included in this section. IVD_SPM2_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Identify excess fetoinfant mortality using the Perinatal Periods of Risk (PPOR) map.				X
2. Activity 2: Complete analyses to identify and prioritize factors with greatest contribution to fetoinfant death disparities.				X
3. Activity 3: Communicate findings of PPOR analyses to stakeholders.			X	X
4. 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 fetoinfant mortality.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: DSHS determined a 2011 fetoinfant death rate of 7.5, with an estimated excess fetoinfant death rate of 1.6. Linked 2012 birth-death files were not yet available at the time of reporting.

Activity 2: PPOR analyses are pending 2012 data. Pprovisional data indicated infant mortality rates of 5.7 in 2011 and 5.5 in 2012, down from 6.0-6.1 in the previous three years. Black infant mortality also declined. DSHS began analyses to examine potential factors associated with this apparent declining trend.

Activity 3: DSHS communicated data related to infant mortality and associated factors to workgroups, Expert Panel members, and coalitions through the Healthy Texas Babies initiative, and to community partners and organizations in all DSHS HSRs.

Activity 4: Staff coordinated and participated in infant health workgroups, committees, partnerships, and trainings. Efforts continued to develop the HTB governance structure. HTB committees developed tools and resources for review by the HTB-EP. The Someday Starts Now campaign launched, including public service announcements, print materials, a barber shop tour, and a tool-rich website at www.somedaystartsnow.com. HTB coalitions continued to implement

interventions to address infant health outcomes based on PPOR findings. The Preconception Peer Educator (PPE) Program was piloted at a historically black university (HBU) and planning began to expand PPE to other HBUs. DSHS continued to disseminate text4baby information.

An attachment is included in this section. IVD_SPM2_Current Activities

c. Plan for the Coming Year

Activity 1: Monitor excess fetoinfant mortality using the Perinatal Periods of Risk (PPOR) map.

Output Measure(s): PPOR map developed for Texas.

Monitoring: PPOR map.

Activity 2: Study and prioritize factors that contribute to fetoinfant morbidity and mortality disparities.

Output Measure(s): Number and type of analyses completed; method for prioritization identified.

Monitoring: Document analyses and priorities.

Activity 3: Communicate fetoinfant morbidity and mortality outcomes and priorities 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 fetoinfant morbidity and 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 percent of active or maintained Title V funded initiatives that include a mental or behavioral health component.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2013	2014	2015	2016	2017
Annual Performance Objective					

Notes - 2012

The MCH Initiatives Survey has been created and will be distributed in July 2013 to appropriate staff. Data for this measure will be available in August 2013.

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: Staff further refined a baseline survey to measure DSHS' capacity to address the integration of mental and behavioral health into MCH programs to ensure question clarity and intent. Title V staff continued communication with MHSA, HHSC and others regarding issues related to prenatal substance use, postpartum depression and childhood developmental issues related to prenatal substance exposure.

Activity 2: Staff assisted THSteps in reviewing final content for provider modules on the following topics: mental, emotional and behavioral disorders; mental health screenings; developmental screening and surveillance and using developmental screening tools. DSHS hosted three "Grand Rounds" presentations related to mental and behavioral health issues -- on suicide, aging and wellbeing and violence in schools.

DSHS staff, along with a representative from the Quad Counties Council on Alcohol and Drug Abuse and presented information at the Behavioral Health Institute in July 2012 on promotores' effectiveness as liaisons with vulnerable communities and assisting people to gain access to needed services. DSHS efforts supported the development of and access to a continuum of substance abuse-related services, from evidence based prevention (indicated and selective) curriculum to post treatment community-based follow-up and motivational enhancement counseling in the Tex-Mex rural border areas. The Rural Border Intervention (RBI) model supported evidenced based substance abuse prevention curriculum with youth and families and interventions with youth and families utilizing a Stages of Change model and Motivational Interviewing with clients.

Staff from the DSHS Office of Border Health and Mental Health and Substance Abuse Division represented the department in the HHSC Office of Border Affairs Colonias Initiative Workgroup and supported efforts to achieve better health, improved self-sufficiency and success for residents along the border and in colonias.

DSHS sponsored a statewide conference for promotores, including sessions increasing knowledge and capacity in addressing behavioral and physical health in MCH populations, including domestic violence, postpartum depression, CHW-led support groups for pregnant women, self-care and stress prevention for health workers, understanding fathers' roles during the perinatal period, effects of alcohol during pregnancy, pregnancy and loss, and motivating families and communities in making health choices.

Activity 3: DSHS worked 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. As of Sept 1, 2011, DSHS implemented a contractual requirement with all Adult Substance Abuse Treatment (TRA) contractors stating, "The Contractor shall provide and document at least one hour of education on

the effects of alcohol, tobacco and other drugs on the developing fetus to all male and female clients prior to discharge."

Activity 4: The Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based assessment that monitors maternal attitudes and behaviors before, during, and after pregnancy. DSHS utilizes the up-to-date information regarding preconception, pregnancy, and birth trends, and serves as an excellent resource in developing policy related to pregnancy and early infancy, including maternal mental health. Texas added three domestic violence questions to the 2012 survey. DSHS and the Texas Healthy Start Alliance (THSA) coordinated efforts to evaluate the status 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. DSHS also continued to utilize the Youth Risk Behavior Surveillance Survey (YRBSS) which is administered to a representative sample of 9-12 graders in Texas and covers a variety of topics related to violence, risk taking behavior, and mental health.

Performance Assessment: Staff continue to support and integrate mental and behavioral health into initiatives and activities. Efforts to continue this integration across DSHS continue to remain a Title V priority.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Assess current level at which programs are working to enhance statewide capacity to address mental and behavioral health for MCH population.				X
2. Activity 2: Develop cross divisional opportunities for programs to increase capacity in addressing mental and behavioral health in MCH populations.				X
3. Activity 3: Partner with internal and external partners to enhance and incorporate mental and behavioral health for MCH populations into their efforts.				X
4. Activity 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 addressing the integration of mental and behavioral health required re-evaluation for additional enhancements to ensure clarity and intent.

Activity 2: Staff assisted THSteps in reviewing content and beta testing for modules related to developmental and behavioral healthscreening and pediatric depression. DSHS hosted 4 "Grand Rounds" presentations related to mental and behavioral health in the M&CH population: Integrated Behavioral Health and Primary Care, Trauma Informed Care, Healthy Texas Babies: Prevention of Subsequent Preterm Delivery in High Risk OB Patients, What Is Causing the Increasing Rate of Mood Disorder in Youth? All presentations were available free of charge to all staff and the general public.

Activity 3: Work continued with the Texas FASD Leadership & Planning Collaborative on the state

goals. A meeting of experts was held in Houston to begin work on creating a community of excellence to serve those with a FASD. The group collaborated with experts in fetal brain development, substance abuse treatment, education, women and pediatric medical providers, the judiciary and others. Title V staff participated in the Infant Mental Health Conference Planning Committee for the April 2014 conference. Training programs approved by DSHS to provide training for promotores planned continuing education events focused on mental and behavioral health.

Activity 4: Updates for this activity will be in the FY13 annual report.

An attachment is included in this section. IVD_SPM3_Current Activities

c. Plan for the Coming Year

Activity 1: Assess current level at which active or maintained Title V funded initiatives that include mental and behavioral health components.

Output Measure(s): Number of on-going activities that incorporate mental and behavioral health components at each of the four levels of change; number of activities that include collaborations that are focused on mental and behavioral health.

Monitoring: Review of activities.

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 the quality of and utilize data sources related to mental and behavioral health.

Output Measure(s): Number of data sources that collect information about mental and behavioral health; number of reports that utilize identified mental and behavioral health data sources.

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)]

Annual Objective and Performance	2008	2009	2010	2011	2012

Data					
Annual Performance Objective	16.5	16	15.5	14.5	12.5
Annual Indicator	15.7	15.0	12.5	16.0	14.2
Numerator	743014	720955	618039	767728	682793
Denominator	4732576	4806369	4937333	4792602	4808400
Data Source	Behavioral Risk Factor Survey				
Is the Data Provisional or Final?				Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	12.5	12	12	11.5	11.5

Notes - 2012

The 2012 data was estimated by calculating the average percent change between 2007-2010, then estimating the 2012 percentage from the 2011 percentage using this average percent change. Denominator is the 2012 projected population from Texas State Data Center of the Office of the State Demographer.

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.

2011 BRFSS data is current. In 2011 the CDC changed it's weighting procedure for the BRFSS, therefore all data from 2011 on will not be comparable to data collected before 2011.

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.

a. Last Year's Accomplishments

Activity 1: 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. From July to November 2011, 49 pregnant women contacted the Quitline for cessation counseling services, including 15 women referred by a health care provider and seven referred by their insurance company. Demographic data noted 33 were White, 12 were Black, and eight were Hispanic. English was report as the primary language for 48 women. All but two of the women reported their age as under 40. Education levels reported included 11 with some college, 16 with a high school diploma or GED and 15 with less than a high school diploma, including three with less than a 9th grade education. All 49 women reported cigarettes as their tobacco of choice. Fifteen of these women also noted a chronic condition, including 10 with asthma, one with coronary artery disease, one with chronic obstructive pulmonary disease, and two with diabetes.

As part of the Title V funded media outreach in FY 2012, DSHS distributed 75,000 posters and brochures in English and Spanish targeting women with children to approximately 150 Title V

clinics in Austin, Lubbock, San Antonio, Tyler/Longview and Fort Bend County.

During FY 2012, providers from throughout the state made 1,067 referrals to the Quitline.

Activity 2: During FY 2012, the Comprehensive Coalitions distributed 32,762 pieces of literature to adults while the Prevention Resource Centers distributed 206,078 for a total of 238,840. These included materials on cessation, prevention and reducing exposure to secondhand smoke messages. The cessation website, www.yesquit.org, had 9,538 hits during FY12. The secondhand smoke website, www.shareair.org, had 852 hits during FY12.

Activity 3: According to 2010 PRAMS data, which is the most recent data available at present, 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 reporting to PRAMS, 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.

The 2011 BRFSS indicated that 16.0% (CI = 13.8% - 18.6%) of Texas women ages 18-44 were current cigarette smokers higher than the annual performance objective of 11.5%. When examined by race/ethnicity, the 2011 BRFSS data showed similar smoking rates among White and Black women 18-44 years, with White women at 22.8% and Black women at 22.2%. An estimated 8.6% of Hispanic women among this age group currently smoked cigarettes. Women with a household income less than \$25,000 had a higher prevalence of current smoking than those with a household income of \$50,000+ (20.7% vs. 11.7%). The 2011 data files contain cell phone data for the first official CDC weighting schematic differed from prior years and is described in detail at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6122a3.htm>. Data results from 2011 should not be combined or compared with prior years due to these changes.

Performance Assessment: Provisional data indicated a continued decline from 2011 to 2012. The 2012 data was estimated by calculating the average percent change between 2007 through 2010 and estimating the 2012 percentage from the 2011 percentage using the average percent change. The integration of tobacco prevention into a variety of public health efforts contributed to the decline in this measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Provide tobacco cessation resources and support to partners working on efforts to improve maternal and child health.				X
2. Activity 2: Distribute cessation and secondhand smoke educational materials through Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Centers.			X	
3. 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.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: DSHS conducted two trainings for clinicians with 53 clinical and non-clinical attendees in December 2012 at the annual DSHS Clinical Care Conference in Austin and in February 2013 at the annual Leander Independent School District staff development conference. DSHS provided compact discs of the on-line clinician training and clinician toolbox to attendees. Clinicians made 407 referrals to the Quitline during this time period.

Activity 2: The DSHS-funded Tobacco Prevention and Control Coalitions, along with the regional Prevention Resource Centers, continued to distribute educational materials on cessation, prevention, and reducing exposure to secondhand smoke.

Activity 3: Updated PRAMS and BRFSS data was not available for analysis at this time. DSHS anticipates having data to report on this measure by summer 2013 for the 2013 Annual Report. **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 clinicians trained in evidence-based, best practices for tobacco cessation.

Monitoring: Number of clinicians who enroll and complete the DSHS on-line training for treating tobacco dependency on the Tobacco Prevention & Control Program's www.yesquit.org web site.

Activity 2: Provide telephone and on-line tobacco cessation counseling services to women ages 18-44.

Output Measure(s): Number of women ages 18-44 who register for services from the state funded cessation provider.

Monitoring: Monthly reports provided by state telephone cessation Quitline contractor.

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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				38	38

Annual Indicator	37.1	39.3	39.4	39.4	39.5
Numerator	1432960	1529673	1508282	1525595	1644050
Denominator	3865559	3894222	3831601	3870381	4163077
Data Source	School Physical Activity & Nutrition Survey	Youth Risk Behavior Survey			
Is the Data Provisional or Final?				Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	37	37	36	36	36

Notes - 2012

The 2012 data were estimated by using the Texas population ages 8-18; multiplying the 4th grade obesity percent by children 8-11, the 8th grade obesity percent by ages 12-14, and the 11th grade obesity percent by ages 15-18.

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.

a. Last Year's Accomplishments

Activity 1: Data analysis indicated that the prevalence of obesity in children in grades 4, 8 and 11 was 23.8, 23.0, and 21.6 % respectively. DSHS developed and disseminated regional fact sheets across the state. The Nutrition, Physical Activity and Obesity Prevention (NPAOP) program also included the SPAN data in the Strategic Plan for Obesity Prevention in Texas.

Activity 2: NPAOP continued work on the ARRA/Communities Putting Prevention to Work

(CPPW) Component I obesity project. As part of the project, NPAOP launched the Plan Healthy Texas website in February 2012. The highly interactive site allows users to build a plan to implement policy, systems, and environmental changes in the school setting to address any of the six CDC target areas. Within the school setting, users can choose their role of school administrator, parent, or teacher. In addition, staff worked with AgriLife, school staff at the eight participating schools and community members to implement their school projects. A NPAOP staff member served as Council Member on the Early Childhood Health and Nutrition Interagency Council and collaborated with representatives of other state agencies to report on obesity prevention activities for children under age six.

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 or implementation at 450 meetings.

Activity 3: The DSHS Division for Disease Control and Prevention released 38 issues of the Friday Beat. Over 7,000 individuals received the Friday Beat weekly. In addition, the school health specialists distributed information related to childhood obesity prevention, nutrition and physical activity to over 22,000 individuals. The DSHS funded school-based health centers provided services to 157 students and their families. NPAOP updated the Strategic Plan for Obesity Prevention in Texas, which includes information and resources about the prevalence and risk factors associated with school-aged childhood obesity. The updated strategic plan will be reviewed and approved by leadership in FY13.

Activity 4: NPAOP funded initiatives to address obesity for children in six communities across the state. Activities supported availability of healthy food choices in public venues, creation of community gardens, participation in a WIC EBT pilot, support for breastfeeding mothers, the extension and creation of trails, installation of new playgrounds, and the creation of a natural playscape.

DSHS regional staff worked with WIC, community and school initiatives, including local coalitions, county extension services, housing authorities, child care centers, Head Start, summer camps, and SHACs to promote obesity prevention, physical activity, assist in developing or expanding community gardens and farmers markets, and to provide worksite wellness information and programs.

Performance Assessment: Texas rates remain above the HP 2020 targets. DSHS continued to implement activities which include 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 to move rates closer to the HP 2020 targets.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Collaborate with 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. Activity 2: Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent school-aged childhood obesity.			X	X
3. Activity 3: Disseminate information and resources about the prevalence and risk factors associated with school-aged childhood obesity.				X
4. Activity 4: Coordinate and implement regional and local			X	X

childhood obesity prevention activities.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The NPAOP epidemiologist analyzed 2009-11 SPAN data for overweight and obesity prevalence among students in relation to demographic characteristics and some risk factors. DSHS created a GIS map showing obesity prevalence and sugar-sweetened beverage consumption among 4th graders.

Activity 2: DSHS continued to participate in the Childhood Obesity Research Demonstration (CORD) Project with the University of Texas School of Public Health. Staff attended Advisory Committee meetings and provided technical assistance and epidemiological information requests.

DSHS regional staff worked with community and school initiatives to promote nutrition, physical activity and provide worksite wellness information. Staff shared relevant data or participated in obesity prevention activity planning at over 200 meetings.

Activity 3: The DSHS funded School-Based Health Centers provided services to 33 students and their families, screening them for overweight and obesity.

Activity 4: Community-based contractors continued to implement child obesity prevention activities. Activities utilized CDC-recommended strategies and target areas for nutrition, physical activity, and breastfeeding.

DSHS regional staff worked with community and school initiatives, including local coalitions, WIC, housing authorities, SHACs and others to promote obesity prevention, physical activity and assisted in developing community gardens and farmers markets.

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 explore opportunities to improve public health in the areas of nutrition, physical activity and related behaviors using the SPAN data set (4th grade children and their parents, 8th graders and 11th graders).

Output Measure(s): Number of publications/manuscripts, posters, abstracts, regional and state level reports; data analysis to identify sociodemographic, social, mental health or other correlates of obesity.

Monitoring: Document meeting or project plans developed; data use in reports, grants or other documents

Activity 2: Partner with external and internal stakeholders to implement collaborative 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 school based health centers.

Monitoring: Review quarterly school based health 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)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				14	11.5
Annual Indicator	14.1	14.5	11.5	11.5	10.9
Numerator	917	954	831	829	752
Denominator	6495224	6557436	7245842	7179876	6902892
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	Mortality Data and Office of the State Demographer
Is the Data Provisional or Final?				Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	11	11	11	10.5	10.5

Notes - 2012

Death file data for 2012 is preliminary and subject to change. When the 2012 file is finalized, we expect this number to increase. The 2012 death file contains more "pending" manners of death than in previous years.

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.

a. Last Year's Accomplishments

Activity 1: Community members explored forming new CFR teams in Angelina, Cherokee, Gregg, Hays, and Maverick counties, as well as a rural team comprised of 10 North Texas counties. New teams in Rockwall County and the Heart of Central Texas CFR team (Brown, Coleman, Comanche and Mills counties) began reviews. Houston and Trinity counties, formerly inactive, reorganized. Staff provided training for the new team membership and the team implemented reviews of child deaths. DSHS facilitated stakeholder meetings in Cherokee, Gregg, and Maverick counties with team formation still pending. Unfortunately, the Heart of Central Texas CFR team disbanded a few months after forming when the agency providing leadership closed. The Western Hill Country CFR team, comprised of Bandera, Gillespie, Kendall and Kerr counties also disbanded in FY12. By the end of FY12, 71 teams covered 205 counties. A total of 93.6% of children live in a county with a CFR process. Team development continued for 11 prospective teams.

Activity 2: The Data Quality Workgroup (DQW) met monthly to address problem areas in data collection and quality that might require changes in policy and practice. DQW developed guidelines for CFR team members using the national database to improve data collection and entry. DQW explored strategies to increase the number of deaths reviewed. DQW developed protocols for expedited review of natural deaths and assignment of deaths to teams for review. Teams received quarterly reports for the calendar year to track number of deaths assigned for review and number of deaths entered in the database. Reports also shared information about team reporting in three areas of focus for data collection improvement: review of natural deaths, sleep-related deaths and child abuse deaths. CFR team members received training on the DQW initiatives and the principles of data collection and entry at the annual conference, done in conjunction with Prevent Child Abuse-Texas (PCAT).

Activity 3: The concept of a State Drowning Prevention Task Force was presented to a wide audience and eight potential task force members were identified. DSHS identified concerns about the lack of coordination between different drowning prevention coalitions and past organizational obstacles. A statewide conference for community health workers provided training on infant water safety. The State Child Fatality Review Team (SCFRT) made recommendations to the governor to recognize April as Water Safety Awareness Month in Texas, a recommendation supported by teams and professional organizations such as Texas Pediatric Society, Texas Medical Association and the Governor's EMS and Trauma Advisory Council. The SCFRT issued an updated Water Safety for Children position statement. Two CFR teams conducted April Pools Day activities, and the SCFRT presented on the multiple activities of the 20-member water safety coalition in Houston/Harris County. Throughout the state, DSHS regional staff partnered with community groups and CFR teams to provide information to the public about water safety and drowning prevention.

Activity 4: The Texas Sudden Unexpected Infant Death Investigation (SUIDI) training team discussed challenges in training and implementing SUIDI in such a large state. DFPS is part of the statewide effort to standardize infant death scene investigations. Staff reviewed materials from the Tennessee child death scene investigation initiative. The annual PCAT conference provided training for CFR team members on the SUIDI protocol. Community members expressed the need for training at the community level. Members of the Texas SUIDI training team (SCFRT medical examiner and CFR coordinator) presented training on the SUIDI protocol at the forensic science conference in Fort Worth to law enforcement, death scene investigators, social workers and others from throughout the North Texas region.

Performance assessment: Preventable child deaths in Texas continue to decrease from 2009-2012. While there have been challenges in select counties maintaining CFRTs, the overall number of CFRTs in Texas remained stable. These teams provided education and training to conduct reviews, collect data, and conduct injury and death prevention activities in their communities. Additional promotion of prevention activities at the state and local levels should continue the decrease in preventable child deaths in Texas.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activity 1: Expand Child Fatality Review (CFR) to cover more children in Texas to increase the understanding of risk and protective factors.			X	X
2. 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.			X	X
3. Activity 3: Organize and facilitate internal and external stakeholders to address prevention of child drowning deaths.			X	X
4. Activity 4: Organize and facilitate internal and external stakeholders to address standardization of infant death scene investigations.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: At mid-year, DSHS received nine inquiries on forming CFRTs, covering 20 counties. Team development is in different stages. Stakeholder meetings were held in three counties and three teams began reviews. There were 69 CFRTs (193 counties) and 6.3% of Texas children lived in counties without CFRTs.

Activity 2: The Data Quality Workgroup (DQW) met every other month to improve data collection and quality. DQW developed two protocols for expedited review of natural deaths and for assignment of deaths to CFRTs. DSHS distributed quarterly reports to help CFRTs keep on track with their data entry and to encourage higher rates of review.

Activity 3: The SCFRT continued to promote the concept of a State Drowning Prevention Task Force. The SCFRT recommended to the Governor and State Legislature and the current legislative session included a resolution that April be recognized as Water Safety Awareness Month. Formal recognition of Texas Water Safety Month will facilitate coordination among coalitions. The Bexar County CFRT formed the Water Awareness through Community Help (WATCH) water safety coalition.

Activity 4: The Sudden Unexpected Infant Death Investigation (SUIDI) Team did not conduct any SUIDI trainings by mid-year FY13. The team planned training for later in FY13.

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 and the implementation of prevention activities on the community level.

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 and/or local teams.

Monitoring: Quarterly review of number of teams and percentage of children living in counties with CFR; review quarterly Health Service Region reports and information from local teams.

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): Maintain 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; number and type of drowning prevention activities related to April as Water Safety Month in Texas.

Monitoring: Quarterly report on progress to organize water safety coalitions and facilitate coordination of drowning prevention efforts in Texas.

Activity 4: Organize, facilitate and track stakeholder efforts to understand infant sleep-related deaths and to standardize practices, messaging and education to prevent these deaths.

Output Measure(s): Promotion of training on standardized infant death scene investigations, number of trainings requested, number of trainings conducted; promotion of infant safe sleep training number of safe sleep trainings conducted; development of directory of trainers statewide.

Monitoring: Quarterly report on progress on organization and tracking of efforts to understand and prevent sleep-related deaths of infants; collection of data on infant sleep-related deaths to monitor trends, focus training promotion efforts, evaluate effectiveness of trainings; and review quarterly Health Service Region reports.

State Performance Measure 7: *The percent of Title V funded initiatives that utilize or promote the use of evidence based practices.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective					
Annual Indicator					
Numerator					

Denominator					
Data Source					
Is the Data Provisional or Final?					
	2013	2014	2015	2016	2017
Annual Performance Objective					

Notes - 2012

The MCH Initiatives Survey has been developed and will be distributed to appropriate staff in July 2013. Data for this measure will be available in August 2013.

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 further refined a baseline survey to measure DSHS' capacity to address the integration of mental and behavioral health into MCH programs to ensure question clarity and intent. Title V staff continued communication with MHSA, HHSC and others regarding issues related to prenatal substance use, postpartum depression and childhood developmental issues related to prenatal substance exposure.

Activity 2: DSHS regional staff that are also certified as instructors for of promotores and community health workers (CHWs) submitted the "Ask About Suicide: To Save a Life" Gatekeeper Training and QPR Gatekeeper Training for Suicide Prevention curricula, evidence-based approaches for suicide prevention, for approval for continuing education credits for promotores and CHWs. Approval was provided in FY13.

DSHS sponsored a statewide conference for promotores and community health workers in August 2012 and included presentations on March of Dimes evidence-based initiatives, such as group prenatal education curriculum called Becoming a Mom™/Comenzando Bien(r) as a strategy to reduce pregnancy outcome inequities, and Healthy Babies are Worth the Wait(r) (HBWW), an initiative utilizing evidence-based interventions to prevent "preventable" preterm births. The conference also included presentations on breastfeeding, including information on the Texas Ten Step Program, developed by DSHS and the Texas Hospital Association, that is based on the World Health Organization (WHO)/ United Nations Children's Fund's (UNICEF) Ten Steps to Successful Breastfeeding, a bundle of evidence-based practices proven to increase breastfeeding exclusivity and duration and reduce racial and ethnic disparities.

Activity 3: DSHS staff and other state agency and community-based organizations continued to promote research-based interventions and strategies through the Healthy Texas Babies (HTB) initiative and coalitions, including expansion of the March of Dimes Stork's Nest program and Healthy Babies are Worth the Wait, implementation of the Young Dads program, development of a Feto-Infant Mortality Review (FIMR) board in Dallas County, development of Mother-Friendly worksites, facilitation with women who delivered an infant with a poor outcome such as low birth weight through a nurse/social worker case management model, and implementation of a public awareness campaign related to a high-risk prenatal clinic.

Promotores and CHWs in south and west Texas received training to screen and educate low-income patients at risk for colon cancer through a three-year evidence-based colon cancer prevention grant awarded to the Texas A&M Health Science Center (TAMHSC) School of Rural Public Health and College of Medicine by the Cancer Prevention and Research Institute of Texas (CPRIT).

Performance Assessment: Research findings and evidence-based practices remained priorities for DSHS. Community-based coalitions through the HTB initiative were required as part of their contracts to develop their programs based on research and evidenced-based practices. The work of the HTB coalitions, along with the training provided to CHWs through the statewide conference, ensured that education provided to stakeholders was based on proven research and evidence-based practices.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.				X
2. Activity 2: Increase cross-divisional opportunities to promote research findings and/or evidence-based practices in DSHS programs serving MCH populations.				X
3. Activity 3: Partner with external and internal stakeholders to identify opportunities to incorporate research findings/evidence-based practices into programs.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The survey to measure DSHS' capacity addressing the integration of mental and behavioral health required reevaluation for additional enhancements to ensure clarity and intent.

Activity 2: Title V staff partnered with the DSHS' Division for Disease Control and Prevention Services to invite promotores, CHWs, and instructors to participate in a Diabetes Empowerment Education Program (DEEP) training in February 2013. The DEEP curriculum must be taught by Master Trainers who have received training from and been certified by the University of Illinois at Chicago that licenses the curriculum. There are only 20 Master Trainers in Texas Department of State Health Services, four of whom are also certified as instructors of promotores or CHWs.

The DSHS Immunization Branch worked to develop an immunization curriculum for use by training programs approved by DSHS to provide initial and continuing education for promotores and CHWs. CHW training programs developed curricula related to evidence-based and best practices for addressing heart health.

Activity 3: Internal and external subject matter experts updated research and evidence-based practice guidelines and materials for re-accreditation on the THSteps Online Provider Education modules for newborn screening, developmental and behavioral health screening, breastfeeding, injury prevention, adolescents and young adults with high-risk behavior, and transition for

CYSHCN.

An attachment is included in this section. IVD_SPM7_Current Activities

c. Plan for the Coming Year

Activity 1: Disseminate findings to DSHS initiatives demonstrating the level at which MCH and/or CYSHCN programs are working to identify and utilize research findings and/or evidence-based practices for serving MCH and/or CYSHCN populations.

Output Measure(s): Number, type, and format of activities identified; number, type and format of activities implemented.

Monitoring: Document materials/products distributed; document activities completed.

Activity 2: Increase cross-divisional opportunities to promote research findings and/or evidence-based practices in DSHS initiatives serving MCH and/or CYSHCN populations.

Output Measure(s): Number, type, and format of activities implemented.

Monitoring: Document materials/products distributed; document activities completed.

Activity 3: Partner with DSHS stakeholders to identify opportunities to incorporate research findings/evidence-based practices into MCH and/or CYSCHN 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; collect materials and plan developed.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	8.4	8.5	8.4	8.5	8.2
Numerator	34230	34157	32490	32718	32114
Denominator	405244	401599	385746	384998	389901
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012

2012 birth data are preliminary and subject to change. Population estimates are from the Texas Data Center of the Office of the State Demographer.

Notes - 2011

2011 data are based on the provisional birth file. These data should be finalized in Aug 2013.

Notes - 2010

Update: 2010 natality data is final.

Narrative:

Provisional data for FY12 indicate a small decrease in the percent of live births weighing less than 2,500 grams from FY11. As noted in various sections of the annual report, Texas has several efforts underway to improve birth outcomes, including the Healthy Texas Babies initiative focusing on reducing infant mortality and preterm births. These efforts include support of local community-based coalitions and other state partnerships as well as a public awareness campaign. With continued support, it is expected that this measure will continue to decrease.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	6.7	6.7	6.7	7.0	6.5
Numerator	26458	26093	25014	25652	24599
Denominator	392755	388736	373694	364802	377420
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012

2012 birth data are preliminary and subject to change. Population estimates are from the Texas Data Center of the Office of the State Demographer.

Notes - 2011

2011 data are based on the provisional birth file. These data will be finalized in Aug 2013

Notes - 2010

Update: 2010 natality data is final.

Narrative:

Low birth weight births among singletons has decreased from the previous year. With efforts of the Healthy Texas Babies initiative, continued support to community-based coalitions, and increased public awareness and education, this percentage is expected to decrease.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	8.7	8.3	7.2	7.1	7.0
Numerator	471	452	413	409	403
Denominator	5384151	5449069	5738590	5763714	5788478
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012

2012 death file is preliminary and subject to change. The population data are estimates from the Texas Data Center of the Office of the State Demographer.

Notes - 2011

The 2011 death file is provisional. The data will be finalized in August 2013.

Notes - 2010

Update: Death data for 2010 are final.
Denominator data from the Office of the State Demographer.

Narrative:

Data indicate the mortality rates related to unintentional injuries has shown continued decreases over the last five reporting periods. Local child fatality review teams throughout Texas and DSHS programs continue to make injury prevention a priority.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	3.5	3.4	3.0	2.7	3.6
Numerator	188	187	173	156	207
Denominator	5384151	5449069	5738590	5763714	5788478
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012

2012 data are from the preliminary death file and subject to change. The population estimates are from the Texas Data Center of the Office of the State Demographer.

Notes - 2011

The 2011 data are provisional and will be finalized in August 2013.

Notes - 2010

Update: Mortality data for 2010 is final.

Denominator data provided by the Office of the State Demographer.

Narrative:

Preliminary data indicate a spike in the death rate due to motor vehicle crashes, following a downward trend over the past four years. DSHS will review final data as it is received and explore alternatives to support focused efforts to address injury prevention with local public health partners and other state agencies, including the Texas Department of Public Safety and the Texas Department of Transportation.

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 CSHCN 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 CSHCN. 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//

/2014/ Texas currently has 69 CRFTs that serve 193 counties. Child population data from 2011 indicates that 92.99% of the total child population (6,220,979 children) live in a county that has CFR coverage. //2014//

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.

/2014/ Title V staff represent Texas on the Safe Sleep Collaborative Improvement and Innovation Network (COIIN). A state strategy has been developed to standardize provision of safe sleep education and training for providers. The goal is to increase provider knowledge and consistent use of safe sleep educational information with pregnant patients and parents of infants by December 31, 2013. Activities to educate providers include a Public Health Grand Rounds session on safe sleep, development of an online education course for providers, and surveys of providers about adoption of standardized safe sleep information shared with patients. //2014//

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 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	33678798	26264110	33750193		31213037	
2. Unobligated Balance <i>(Line2, Form 2)</i>	9306829	12610607	14546974		3932132	
3. State Funds <i>(Line3, Form 2)</i>	46105185	40208728	40208728		40208728	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	290902	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	2527780	0	0		0	
7. Subtotal	91909494	79083445	88505895		75353897	
8. Other Federal Funds <i>(Line10, Form 2)</i>	626031673	546960482	554335767		546757096	
9. Total <i>(Line11, Form 2)</i>	717941167	626043927	642841662		622110993	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	3481486	11758643	8898022		11204109	
b. Infants < 1 year old	54268	146641	77886		139725	
c. Children 1 to 22 years old	20081460	18979175	23529960		18084124	

d. Children with Special Healthcare Needs	44833549	36212246	42487766		34504489	
e. Others	17336457	7646832	6919094		7286210	
f. Administration	6122274	4339908	6593167		4135240	
g. SUBTOTAL	91909494	79083445	88505895		75353897	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	133669		65357		66392	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	598926315		528927444		522600572	
h. AIDS	0		0		0	
i. CDC	8589827		8582354		8063478	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
FamilyPlanning (T-X)					15400847	
NHSCPC/MaleInvolve					625807	
Family Plan (TitleX)			16059276			
NHSCPC/Male Involvem	701336		701336			
Family Planning X	17680526					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	68695349	37676740	61079763		35899919	
II. Enabling Services	5057173	5120096	5557015		4878634	
III. Population-Based Services	9142487	16124715	8558596		15364279	
IV. Infrastructure Building Services	9014485	20161894	13310521		19211065	
V. Federal-State Title V Block Grant Partnership Total	91909494	79083445	88505895		75353897	

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//

/2014/ 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 FY11 and FY12 as of 7/2/13. Field Notes have also been added to update the individual cells of the tables where needed. The budgeted amounts for FY14 are estimated since the federal award may change in FY14, and FY13 expenditures are not final. //2014//

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//

/2014/ Form 3 in TVIS does not include a complete update to budget and expenditure amounts. Please refer to Attachment V. A. Note that the federal allocation has been

decreased by almost 10% since FY2009. In addition, beginning in FY12, the state no longer budgets general revenue funding in excess of the Maintenance of Effort amount.
//2014//

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//*

/2014/ Form 4 in TVIS does not include a complete update to budget and expenditure amounts. Please refer to Attachment V. A. //2014//

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//*

/2014/ Form 5 in TVIS does not include a complete update to budget and expenditure amounts. Please refer to Attachment V. A. Of the total state-federal partnership funding, expenditures for Direct Services have dropped from 72% in FY2009 to 46% in FY2013 as of this submission. During the same period, expenditures for Population Based Services have increased from 14% to 24% of the total, and Infrastructure Building Services increased from 8% to 22%. //2014//

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//

/2014/ The commitment of general revenue for FY14 remains limited to the MOE requirement of \$40,208,728. The final state budget appropriations in the General Appropriation Act, Senate Bill 1, 83rd Regular Session are under review and the DSHS Operating Budget for FY14 has not been finalized. //2014//

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//

/2014/ DSHS remains committed to comply with the procedures noted above to allocate and spend at least 30% of the federal allotment for preventive and primary services for children as well as 30% for children with special health care needs.

For FY14, the projected budget shows that \$9,363,911 of the federal Title V awarded funds are specifically marked for preventive and primary care for children while \$9,363,911 are also earmarked directly for children with special health care needs. These dollar amounts, based on the projected FY14 federal allocation (projected award based on equal funding to projected FY13 federal allocation), will ensure that Texas complies with the 30/30 federal requirement. //2014//

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//

/2014/ The state incurred reductions in federal funds as a result of sequestration in FY2013, including a reduction of \$1.9 million in the Title V award. DSHS funding for family planning services was reduced with the loss of the Title X Family Planning award. Additional changes in federal funding in other health and human service programs and agencies are being monitored to assess challenges that impact services to Texans.

Although the 83rd Legislature of Texas did not choose to expand the state's Medicaid program as allowed under the Affordable Care Act, the body appropriated additional General Revenue funding for the 2014-2015 Biennium. These funds are to be used to expand primary health care, mental health and substance abuse treatment services for children and adults. //2014//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

July 15, 2013

Title V Block Grant
HRSA Grants Application Center
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879

To Whom It May Concern:

As Assistant Commissioner of Family and Community Health Services for the Texas Department of State Health Services, I hereby submit this letter to apply for the Maternal and Child Health Services Title V Block Grant funds for federal fiscal year 2014. The online application has been completed in accordance with this year's grant guidance.

Should you have questions or need additional information, please contact Sam B. Cooper, III, Director, Office of Title V and Family Health at 512-776-7373 or me at 512-776-7321. Thank you for your consideration and review of the Texas Maternal and Child Health Services Title V Block Grant Application for FY 2014 and Annual Report for FY 2012.

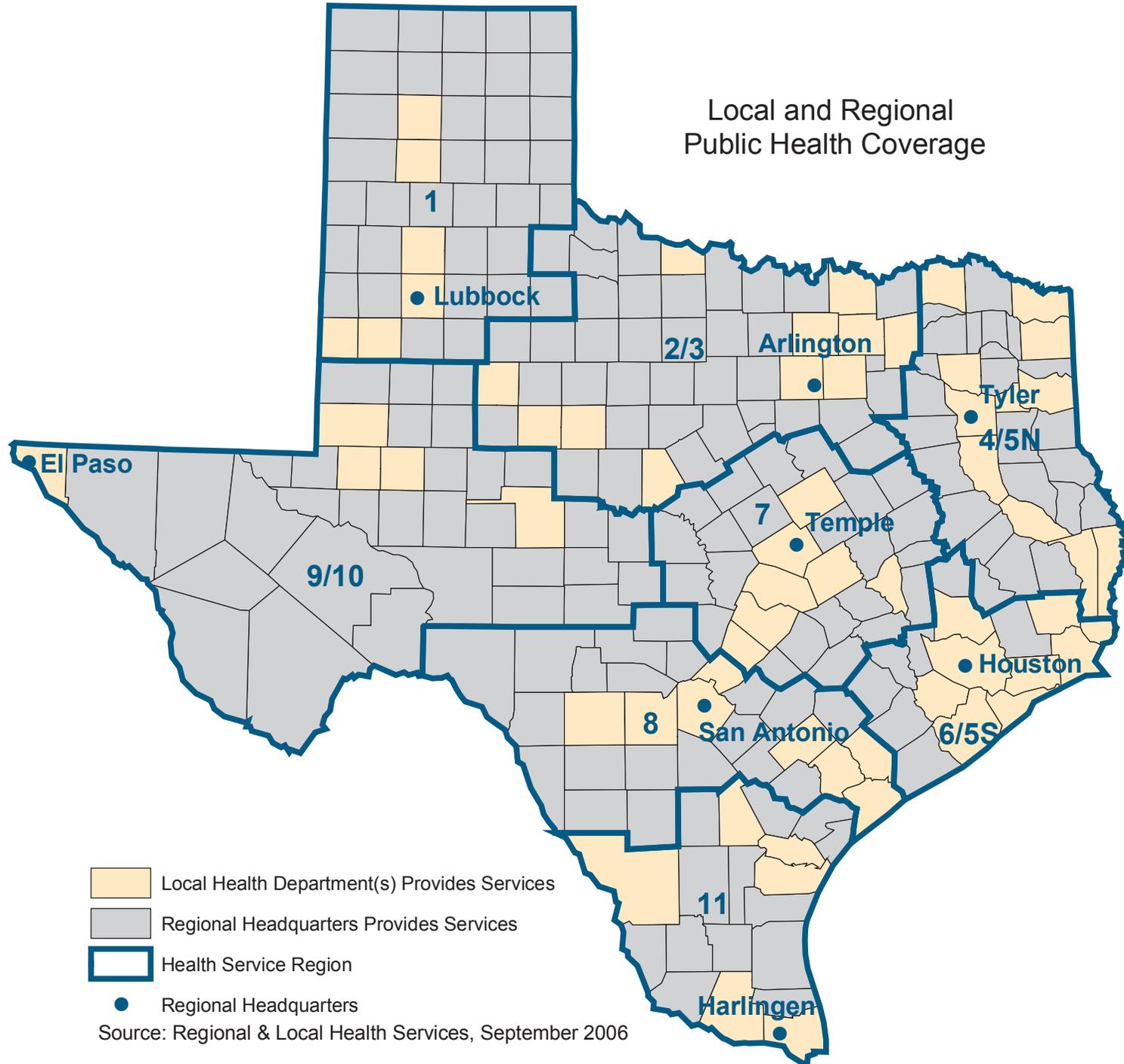
Sincerely,

A handwritten signature in cursive script that reads "Evelyn Delgado".

Evelyn Delgado, Assistant Commissioner
Family and Community Health Services

Attachment

Local and Regional Public Health Coverage



83rd Texas Legislative Session Summary
Selected Bills Relating to Maternal and Child Health
January – June 2013

The 83rd Legislature, Regular Session ended on May 27, 2013. The First Called Session ended June 25, 2013. The following table includes a brief overview of key legislation impacting maternal and child health in Texas. (prepared July 2013)

Behavioral Health
<p><u>SB 44</u> – Requires DFPS to track the number of children with severe emotional disturbances in state conservatorship due to voluntary relinquishment. Directs DFPS and DSHS to develop recommendations to prevent relinquishment solely to obtain mental health services and report findings to the Council of Children and Families and legislature.</p> <p><u>SB 50</u> – Adds mental health to the legislative charge of the Children’s Policy Council.</p> <p><u>SB 58</u> – Requires HHSC to integrate behavioral and physical health services in Medicaid managed care by 09/01/14 and establishes two health home pilots for persons diagnosed with a serious mental illness and at least one other chronic health condition.</p> <p><u>SB 421</u> – Requires HHSC to form a consortium to have responsibility for developing criteria for and oversight over the Texas System of Care and the development of local mental health systems of care for certain children in communities for minors who are receiving residential mental health services or inpatient mental health hospitalization or who are at risk of being removed from the minor’s home and placed in a more restrictive environment to receive mental health services.</p> <p><u>SB 460</u> – Requires minimum academic qualifications for educator certification to include training to detect students with mental or emotional disorders.</p> <p><u>SB 831</u> – Requires DSHS, in coordination with TEA and regional education service centers, to provide and annually update a list of best practice mental health, substance abuse, and suicide prevention programs that may be selected for implementation by public schools, appropriate for implementation in the district.</p>
Child Care
<p><u>HB 376</u> – Reinstates funding for the Texas Rising Star program for childcare and provides incentives for achieving higher levels of quality of care through increased reimbursement rates.</p>
Child Safety
<p><u>HB 1741</u> – Requires all licensed childcare centers with large vans or buses to install electronic child safety alarms in their vehicles.</p>

**83rd Texas Legislative Session Summary
Selected Bills Relating to Maternal and Child Health
January – June 2013**

Children and Youth with Special Health Care Needs
<p><u>HB 617</u> – Requires each school district or special education co-op to designate at least one employee as the designee on transition and employment services for special education students.</p> <p><u>SB 7</u> – Establishes an advisory committee for a delivery system redesign related to the provision of Medicaid acute care services and long-term services and supports to individuals with intellectual and developmental disabilities. Directs HHSC to create STAR KIDS, a mandatory managed care program for children with disabilities incorporating health homes and creates a STAR KIDS Managed Care Advisory Committee and an Intellectual and Developmental Disability System Redesign Advisory Committee.</p>
Environmental Safety
<p><u>SCR -1</u> – Designates April as Water Safety Month for a 10-year period beginning in 2013.</p>
Family Reunification/Permanency Planning
<p><u>SB 352</u> – Raises the minimum standards and practice for children in the Temporary Managing Conservatorship of the Department of Family and Protective Services if these children have a permanency goal of reunification.</p>
Health Information
<p><u>SB 1795</u> – Authorizes the Insurance Commissioner to establish standards and qualifications for Navigators assisting consumers with accessing the federal Marketplace if federal standards are determined insufficient.</p> <p><u>SB 1815</u> – Requires the Department of Public Safety to designate a nonprofit organization to establish, maintain and administer a statewide Internet-based registry of organ, tissue, and eye donors registry, to be known as the Glenda Dawson Donate Life-Texas Registry.</p>
Maternal and Infant Mortality
<p><u>HB 2620</u> – Establishes a 25-member task force, including two representatives of the family and community health programs in the Department of State Health Services, to examine the impact of domestic violence on maternal and infant mortality, the health of mothers, and the health and development of fetuses, infants, and children; and investigate, and make recommendations relating to the coordination of health care services.</p> <p><u>SB 495</u> – Creates a 15-member multidisciplinary advisory committee within the Department of State Health Services, Maternal Mortality and Morbidity Task Force, to study maternal mortality and severe maternal morbidity, and make recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in this state.</p>

**83rd Texas Legislative Session Summary
Selected Bills Relating to Maternal and Child Health
January – June 2013**

Medicaid & Health Programs

HB 595 – Requires a review of certain health programs, panels, councils, systems, foundations, centers, committees, and divisions under the Texas Sunset Act, and the transfer of certain functions to the Department of State Health Services.

SB 8 – Requires a review of service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service contracts.

SB 872 – Allows a county intergovernmental transfer of expenditures for certain health care services to the state toward eligibility for state assistance if the transfer was made to provide health care as part of the Texas Healthcare Transformation and Quality Improvement Program waiver.

Neonatal and/or Maternal Services

HB 15 – Requires levels of care designations for hospital that provide neonatal and maternal services.

HB 1605 - Establishes a pilot program in Harris County to provide maternity care management to certain women enrolled in the Medicaid managed care program.

SB 426 – Requires HHSC to create a strategic plan to serve at-risk pregnant women and families with children under the age of six through home visiting programs that improve outcomes for parents and families, including ensuring appropriated funds are used in evidence-based and promising practices programs.

Physical Activity, Nutrition, and Obesity

HB 1018 - Establishes community partnerships and the development of policy recommendations for increasing physical activity and improving fitness among public school students.

Prevention of Child Abuse and Neglect

SB 66 – Delineates the composition of the child fatality review team committee, whose membership includes one member representing the Office of Title V and Family Health of the Department of State Health Services appointed by the office director, and requires the committee to examine the causes of and makes recommendations for reducing child fatalities, including fatalities from the abuse and neglect of children. Creates the “Protect Our Kids Commission” to make recommendations related to reducing fatalities from child abuse and neglect and tracking information to improve interventions.

**83rd Texas Legislative Session Summary
Selected Bills Relating to Maternal and Child Health
January – June 2013**

Prevention of Child Abuse and Neglect (continued)

SB 245 – Provides for the eligibility of children's advocacy centers for contracts to provide services for children and family members in child abuse and neglect cases, including certain required components.

SB 939 – Requires all new school employees to receive training in recognition and prevention of child sexual abuse. Requires all institutions of higher education to adopt a policy regarding reporting of child abuse and neglect and provide training to professionals in recognition and prevention of child sexual abuse.

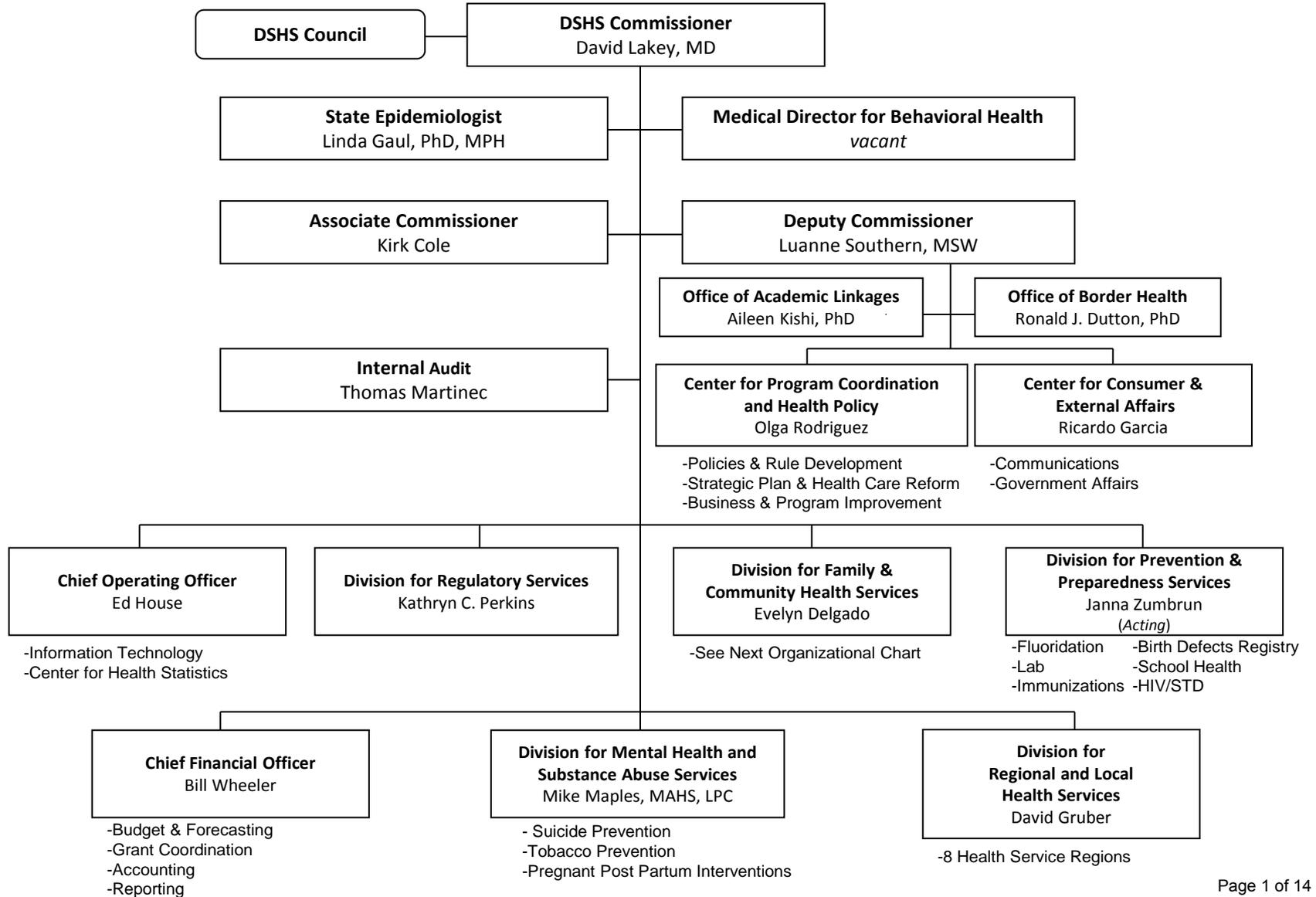
Screening for Newborns and Children

HB 740 – Permits the Department of State Health Services, with the advice of the Newborn Screening Advisory Committee, to authorize a screening test for critical congenital heart disease to be performed at a birthing facility that provides care to newborn patients.

SB 504 - Eliminates the requirement that certain schoolchildren be screened for abnormal spinal curvature.

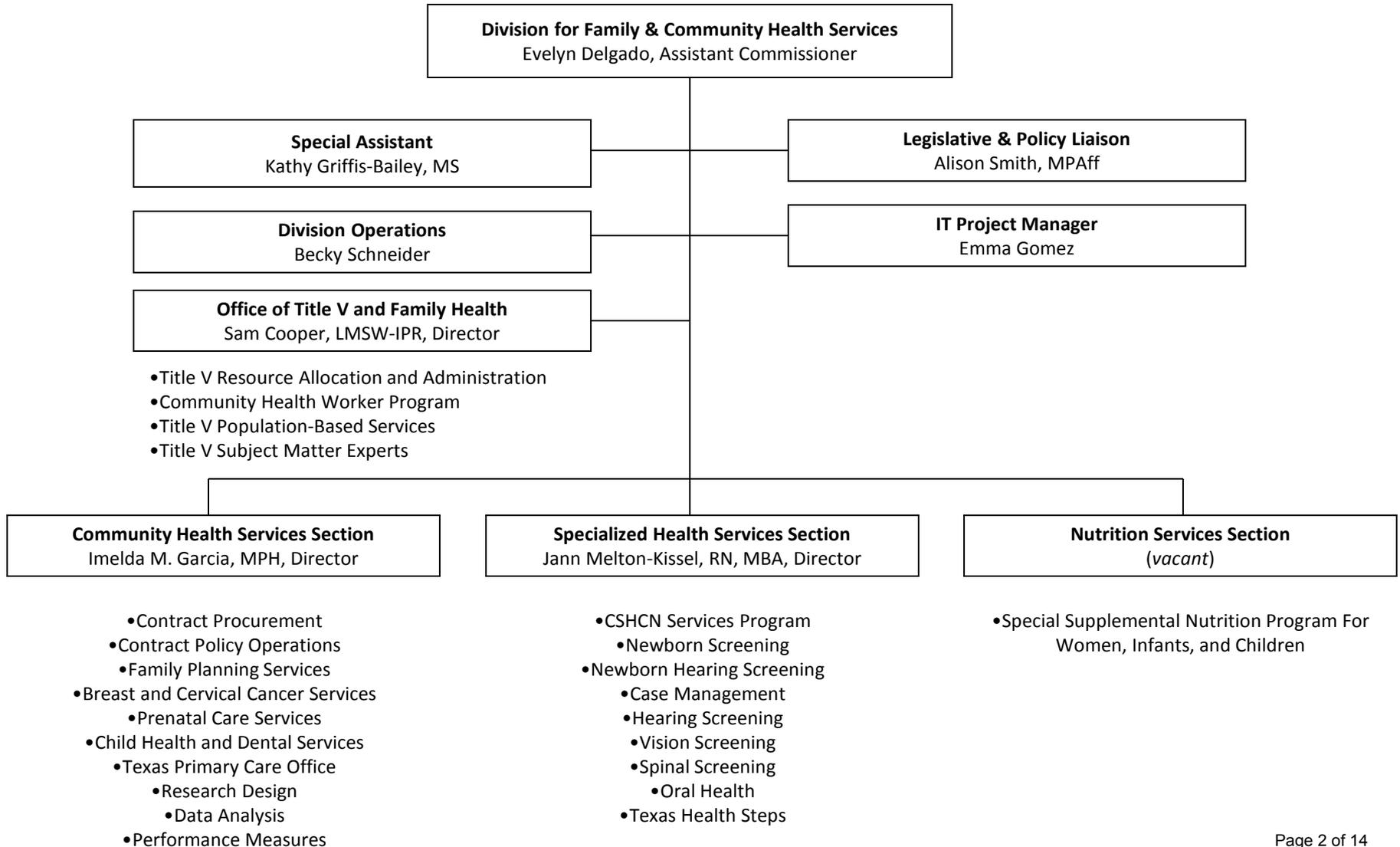
SB 793 – Requires a birthing facility to perform or by referral to a certified program, a hearing screening for the identification of hearing loss on each newborn or infant born at the facility before the newborn or infant is discharged from the facility, under certain conditions.

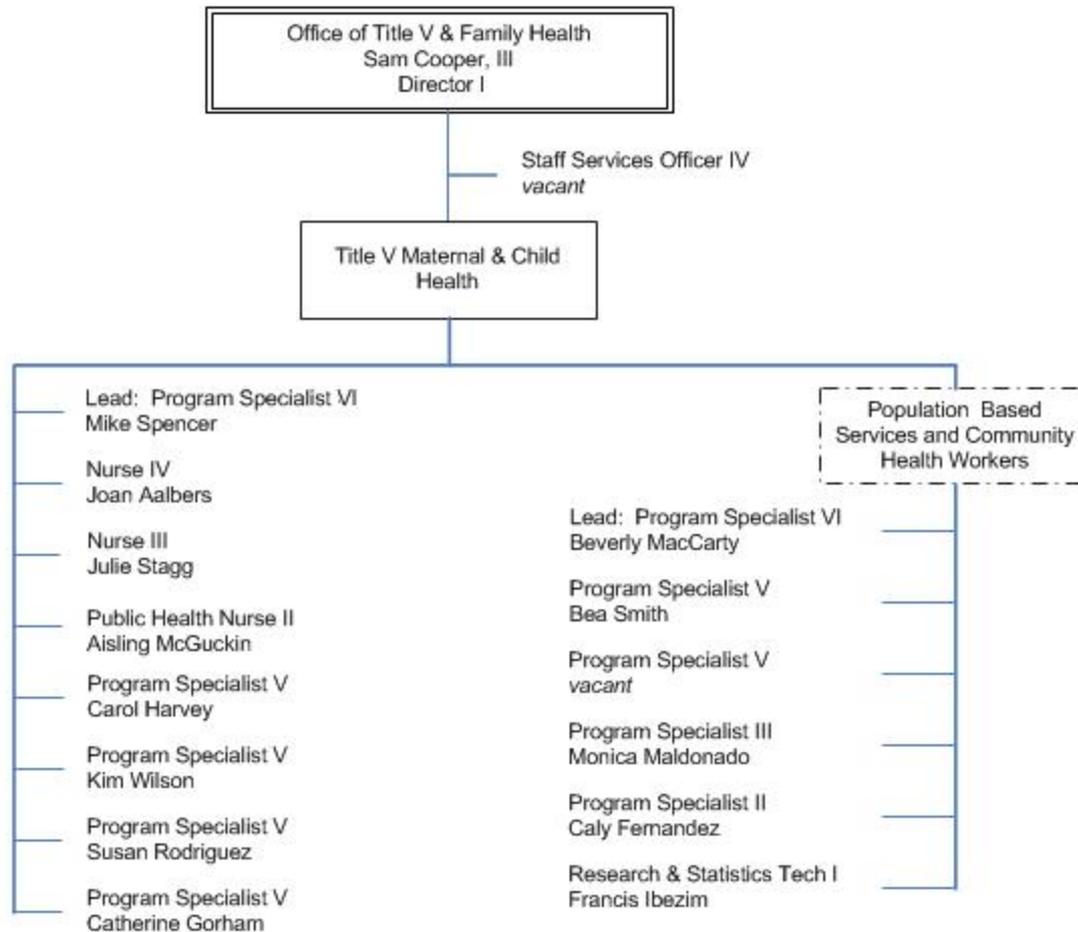
Texas Department of State Health Services
June 2013

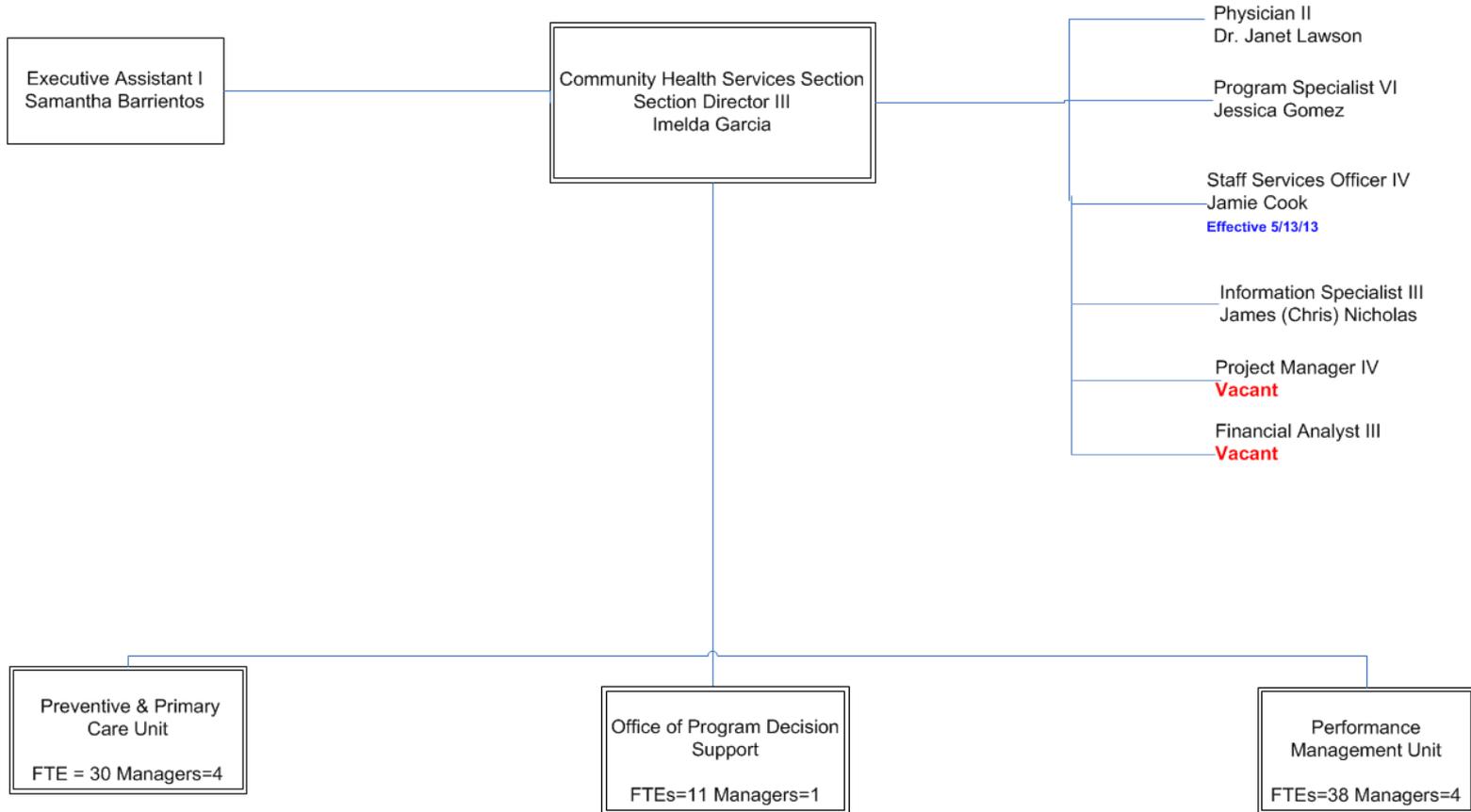


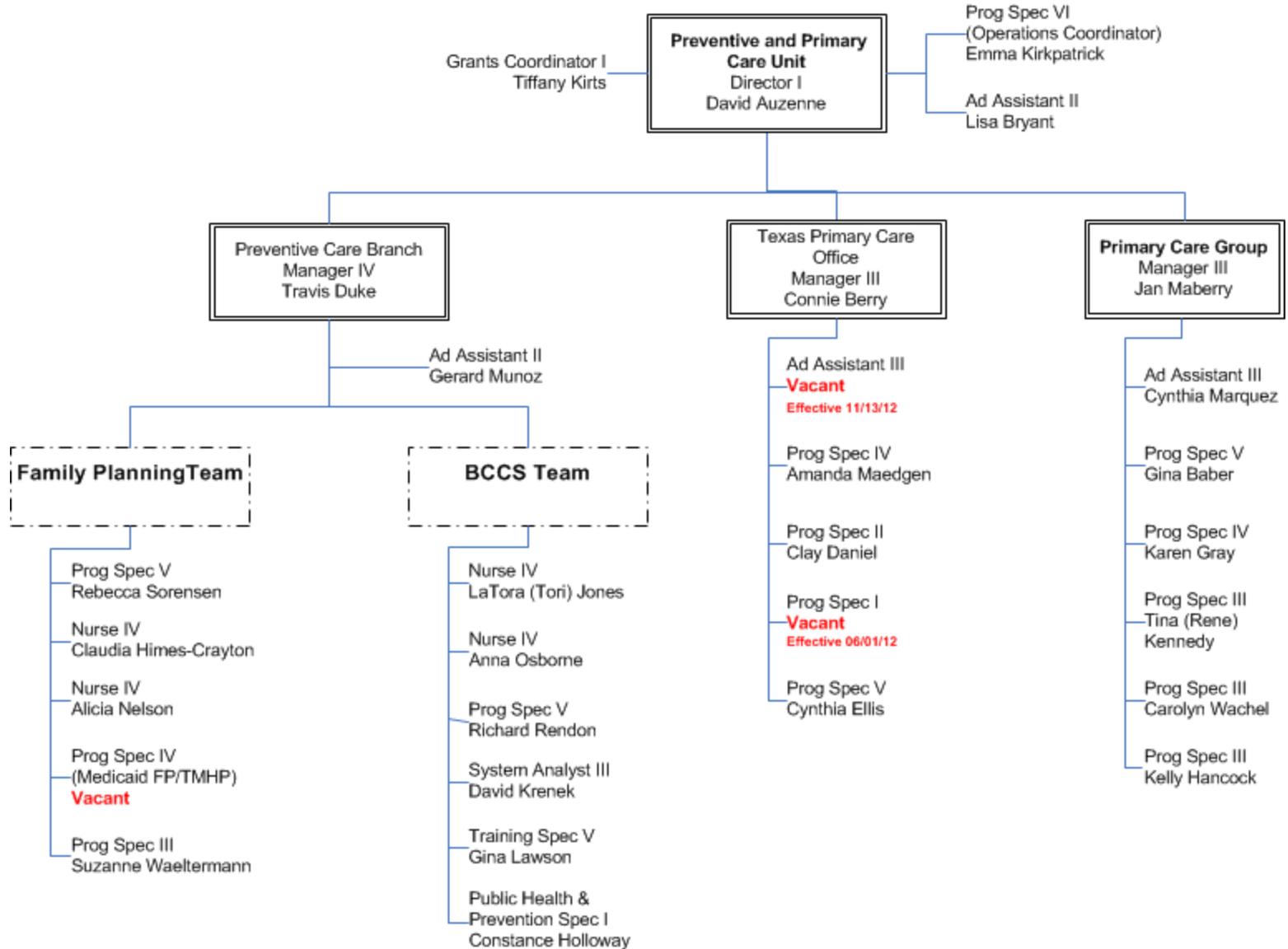
Division for Family & Community Health Services

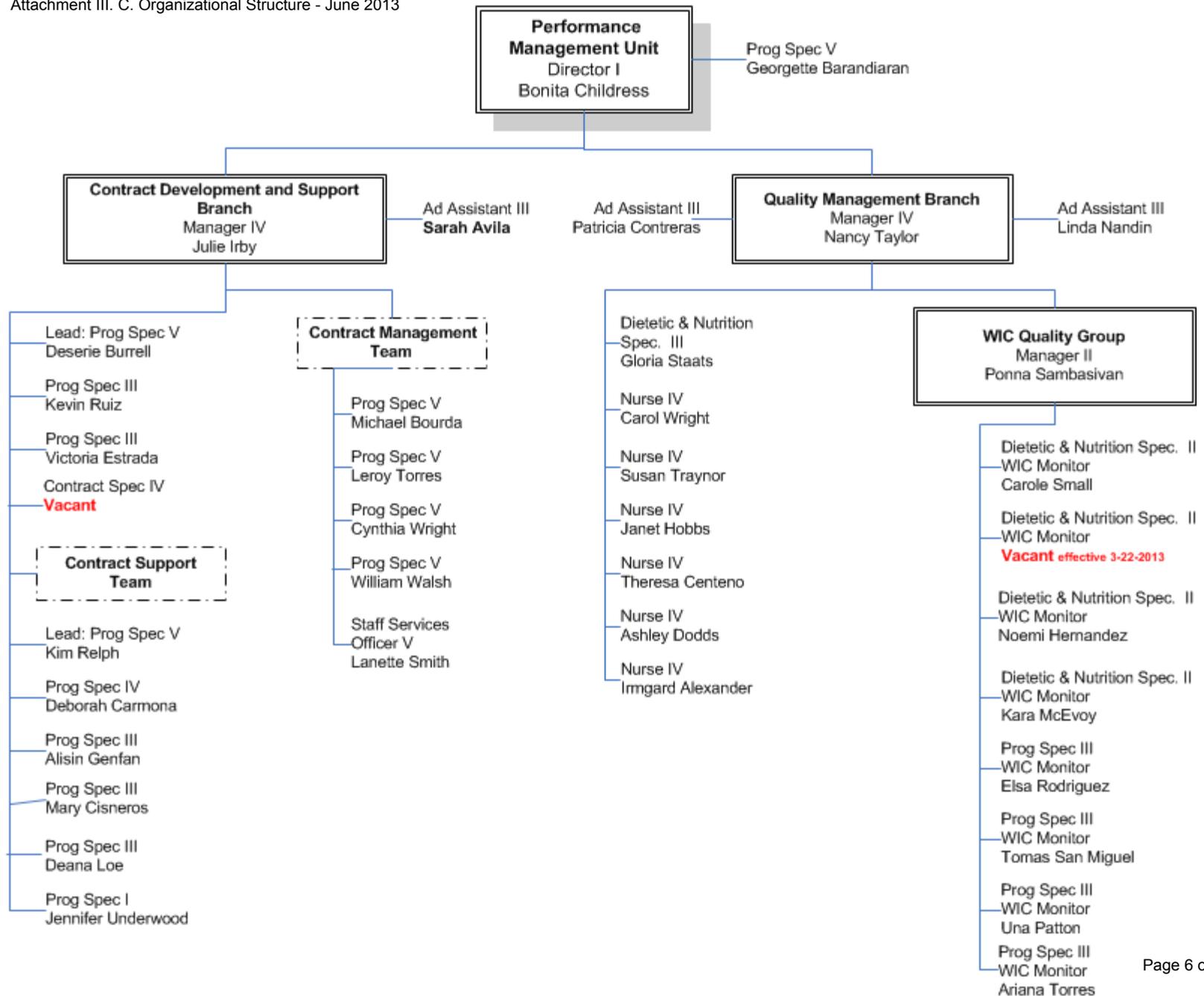
Title V Support and Resources

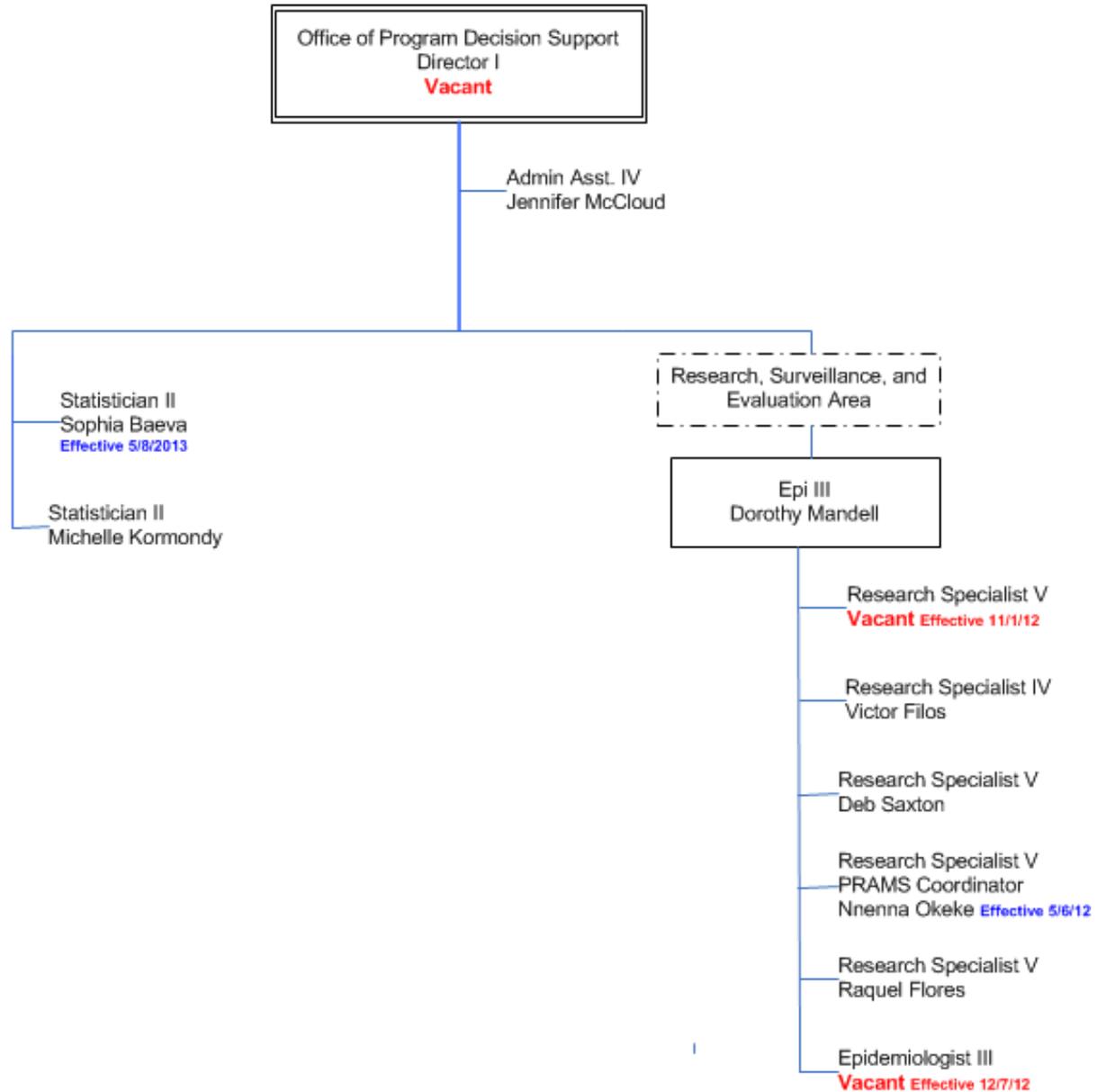


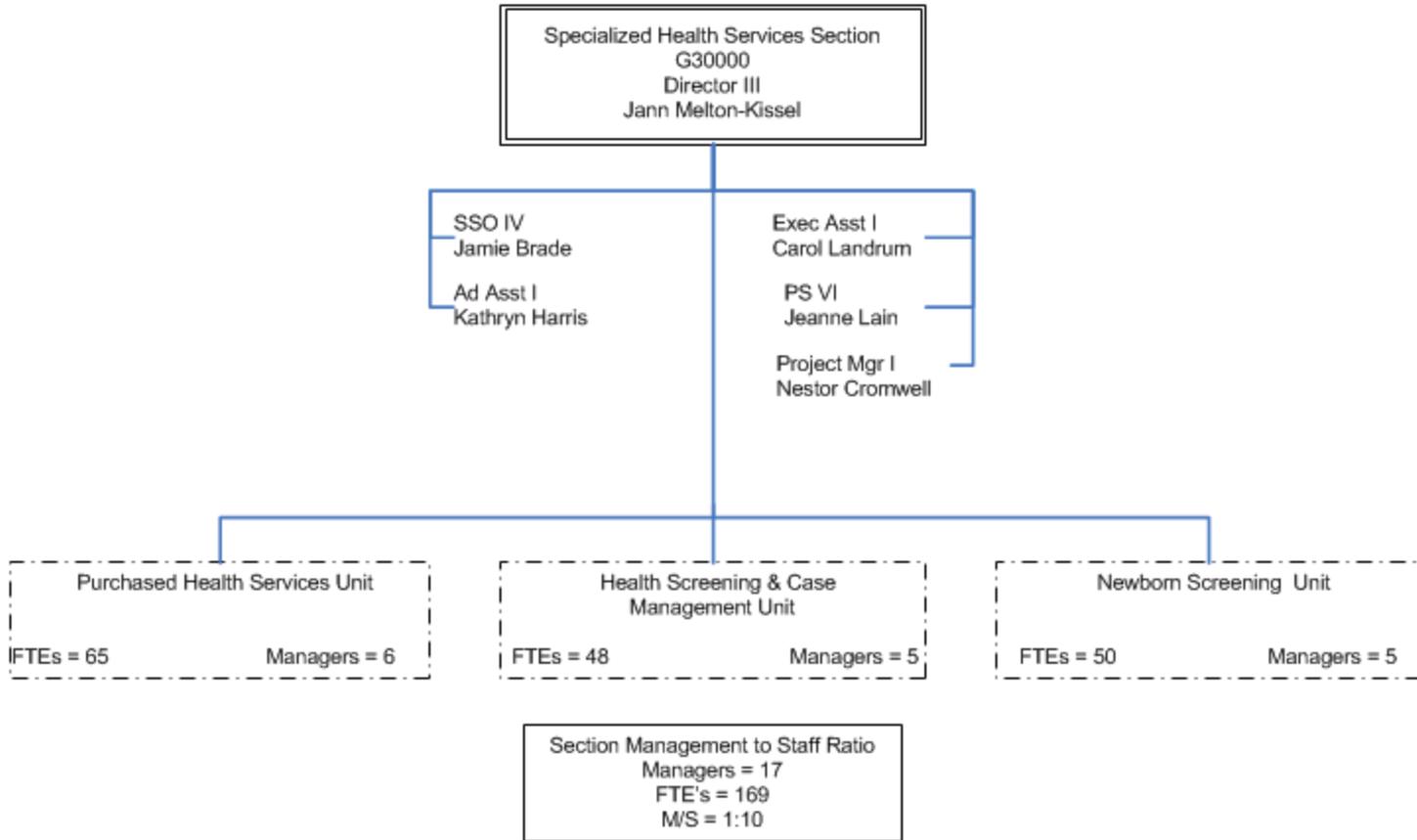


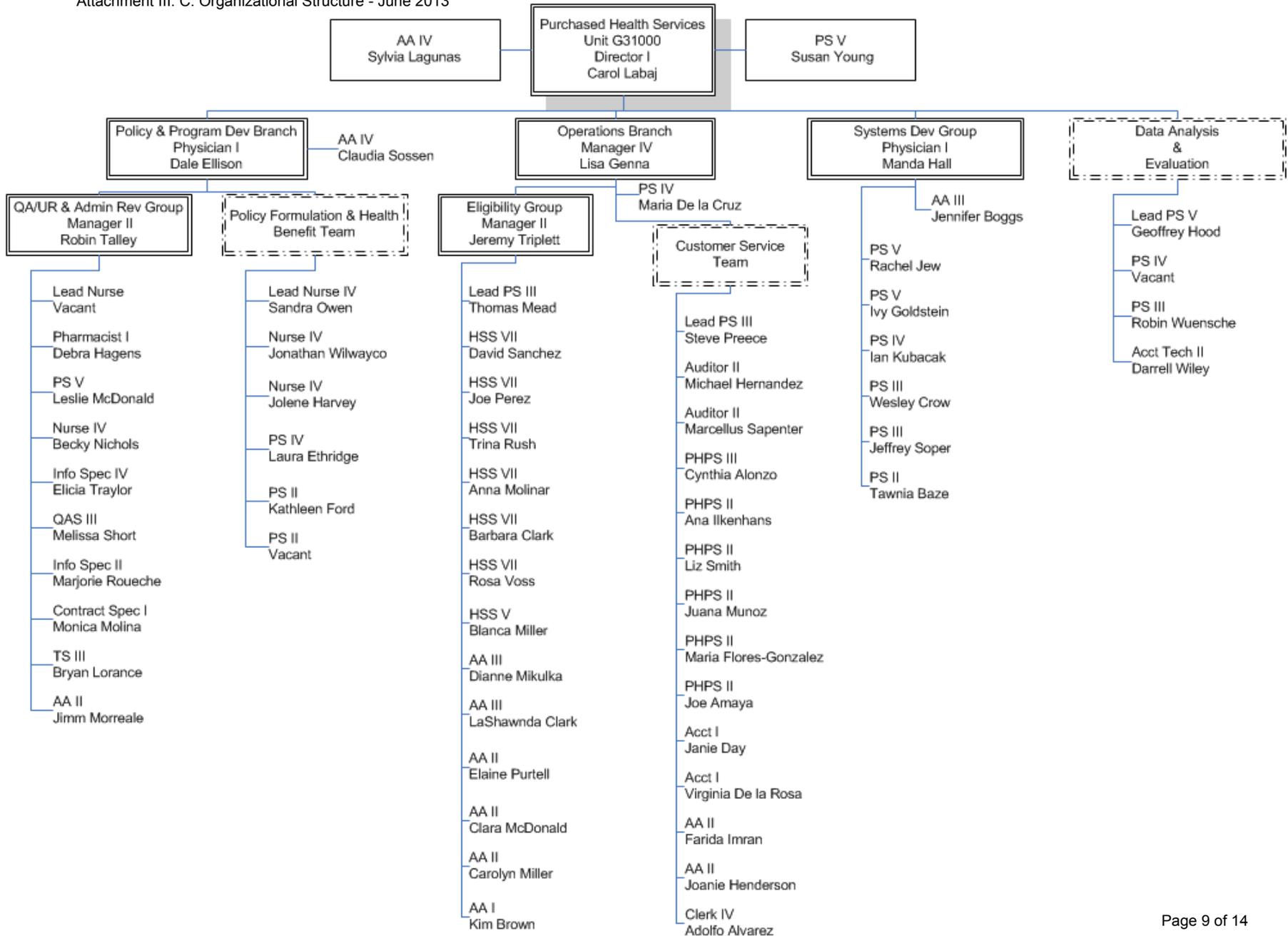


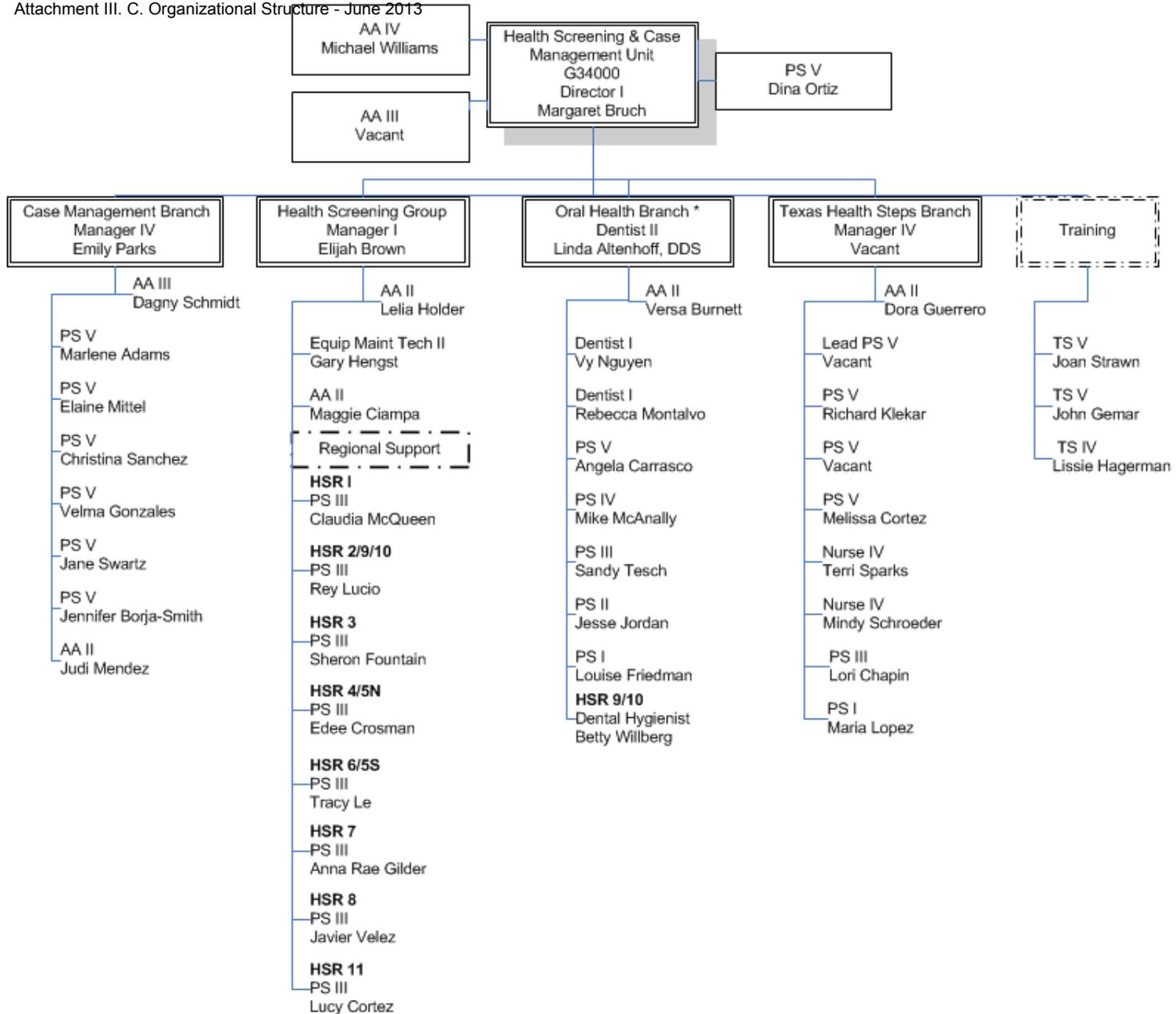


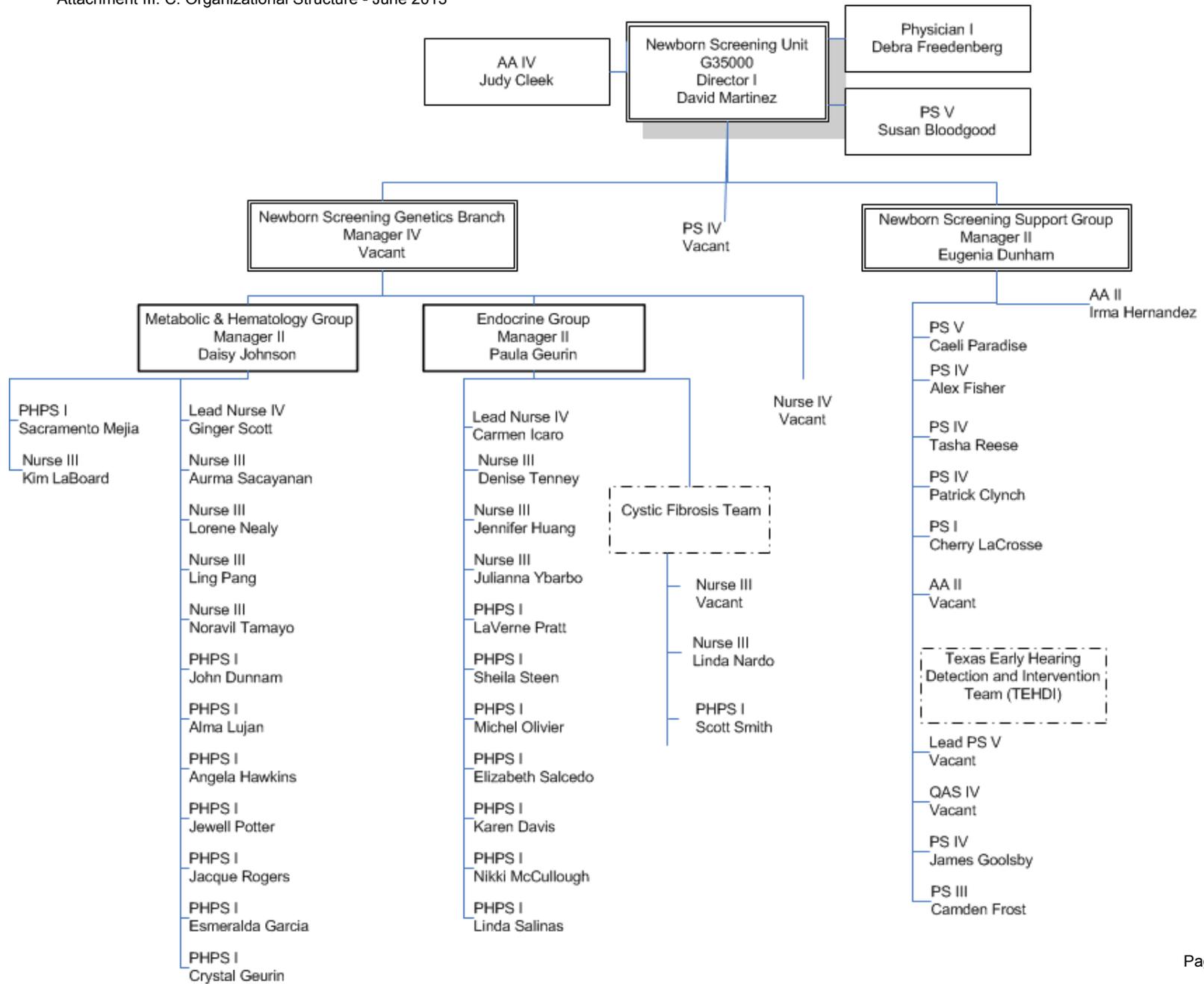


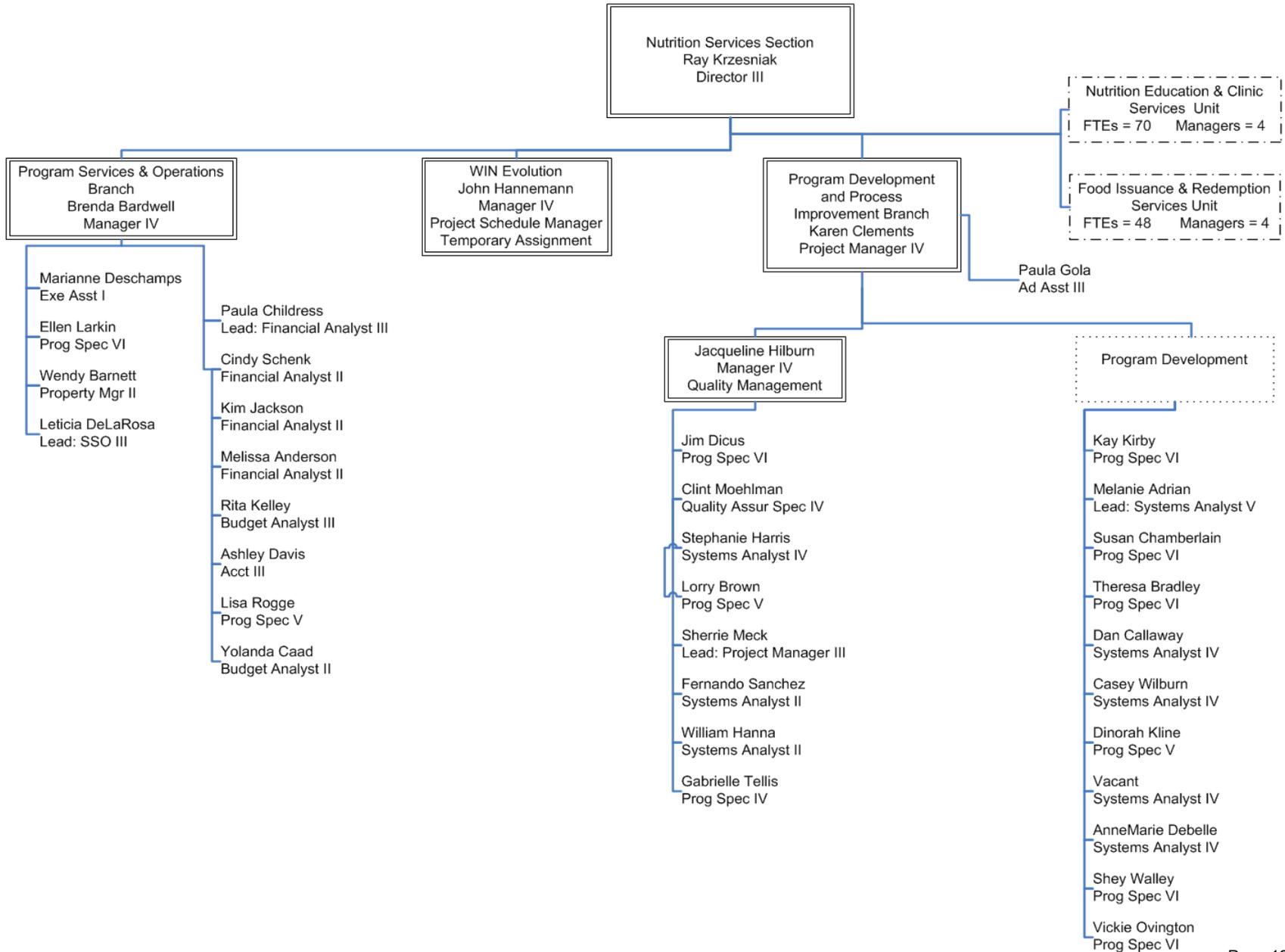




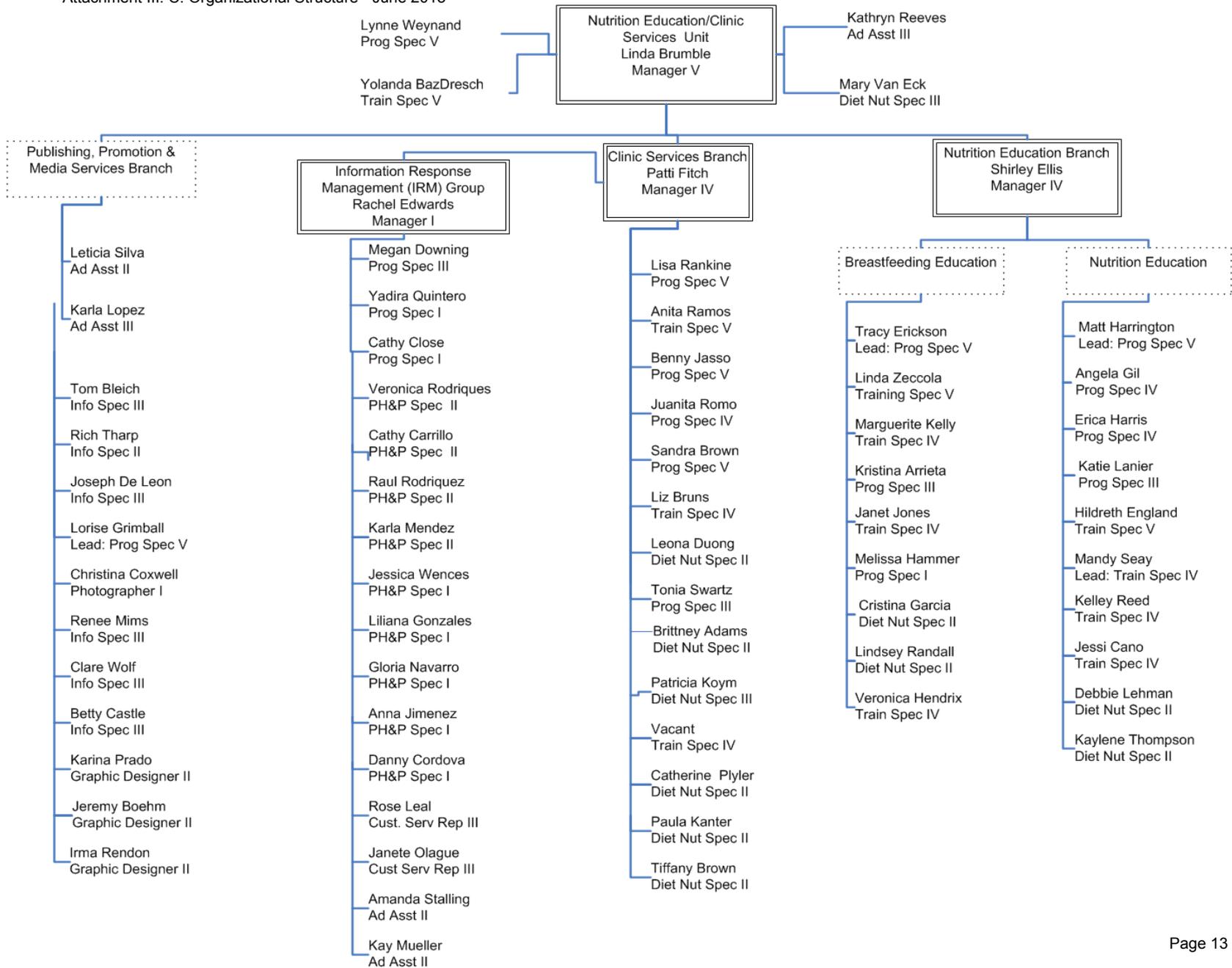








Attachment III. C. Organizational Structure - June 2013



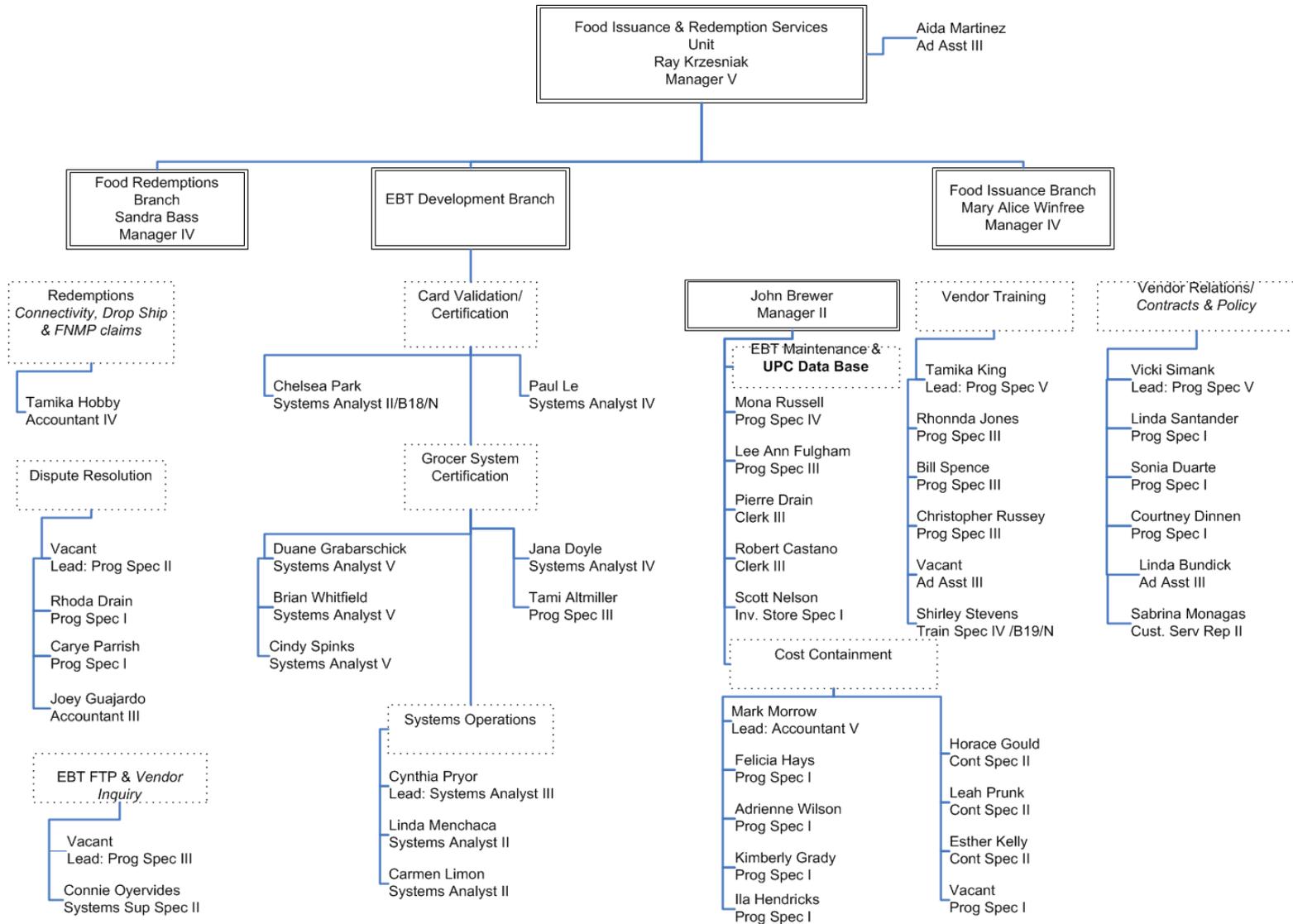


Table 1: FY13 Number and Classifications of DSHS Personnel Funded by the Federal-State Title V Program

Job Description	TitleV-funded Staff in Central Office	Title V-funded Staff in Health Service Regions (HSR)									Total FTEs Funded by Title V
		HSR 1	HSR 2/3	HSR 4/5	HSR 5/6	HSR 7	HSR 8	HSR 9/10	HSR 11	HSR Total	
Accounting Technician	0.48									0.00	0.48
Administrative Asst	13.96	1.60	7.90	1.80	4.10	2.50	2.50	4.27	2.55	27.22	41.18
Attorney	0.15									0.00	0.15
Clerk	0.00			0.40			3.57	0.70	1.40	6.07	6.07
Contract Administration Manager	0.06									0.00	0.06
Contract Specialist	1.04									0.00	1.04
Data Base Administrator	0.25									0.00	0.25
Dental Hygienist	1.00	1.00		1.00	1.00		1.00			4.00	5.00
Dentist	3.00	1.00		1.00	1.00		1.00			4.00	7.00
Dietetic and Nutrition Specialist	0.05			1.00						1.00	1.05
Direct Care Public Health Nurse	0.00		0.41	2.00			1.16			3.57	3.57
Director	3.76									0.00	3.76
Engineer	1.00									0.00	1.00
Engineering Specialist	1.00									0.00	1.00
Epidemiologist	0.75									0.00	0.75
Equipment Maintenance Tech	0.50									0.00	0.50
Executive Assistant	1.04									0.00	1.04
Human Services Specialist	4.25	2.60	3.70	7.93	9.24	3.05	3.40	2.96	4.81	37.69	41.94
Human Services Technician	0.00			3.89		7.00	5.94	3.98	1.00	21.81	21.81
Information Specialist	3.22									0.00	3.22
Manager	4.55	1.20	0.35	0.30	0.60	1.40	1.40	0.40	1.20	6.85	11.40
Medical Technologist	23.00									0.00	23.00
Microbiologist	1.00									0.00	1.00
Network Specialist	0.36									0.00	0.36
Nurse	11.03	2.00	2.86	4.00	2.26	2.50	5.69	3.03	0.50	22.84	33.87
Pharmacist	0.36									0.00	0.36
Physician	2.45									0.00	2.45
Pop-Based Srvs Pub Health Nurse	0.00		0.91	3.79	0.92	2.00	1.70	2.34		11.66	11.66
Program Specialist	47.36	2.00	5.71	3.83	4.62	5.41	1.15	2.88	1.93	27.53	74.89
Program Supervisor	3.00									0.00	3.00
Project Manager	0.58									0.00	0.58
Public Health and Prevention Specialist	18.67			2.25	3.50	1.50	0.30	0.35	4.68	12.58	31.25
Public Health Nurse	1.00						0.05			0.05	1.05
Quality Assurance Specialist	0.60									0.00	0.60
Research & Statistics Tech	0.37									0.00	0.37
Research Specialist	1.46									0.00	1.46
Social Worker	0.00	0.26								0.26	0.26
Staff Services Officer	3.09									0.00	3.09
Statistician	1.40									0.00	1.40
System Analyst	6.00									0.00	6.00
Training Specialist	0.75									0.00	0.75
Total	162.54	11.66	21.84	33.19	27.24	25.36	28.86	20.91	18.07	187.13	349.67

Note: Within the positions listed in these tables, licensed social workers are employed in the state classifications as Managers, Program Specialists, Social Workers, and Human Service Specialists.

Title V FY 13 Activity Plan – NPM 01

National Performance Measure 01: <i>The percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for conditions mandated by their state-sponsored newborn screening program.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Monthly review of percent increase/decrease in unsatisfactory specimens and tracking of dissemination of materials.</p>			X	
<p>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.</p> <p><u>Output Measure(s)</u>: Type and number of materials distributed and website hits.</p> <p><u>Monitoring</u>: Document distribution of materials and interactions with stakeholders.</p>			X	
<p>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.</p> <p><u>Output Measure(s)</u>: Brochure available in English and Spanish, on the MCH webpage, and in hard copy.</p> <p><u>Monitoring</u>: Ensuring posting of brochure on website and notification/distribution to key stakeholders.</p>			X	

Title V FY 13 Activity Plan – NPM 01

National Performance Measure 01: <i>The percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for conditions mandated by their state-sponsored newborn screening program.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 4: Implement identified measures that link the quality of patient care with the quality of pre-analytical stages of the newborn screening process.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Measures will be tracked using statistical reports from Laboratory Information Management System (LIMS).</p>				X

Title V FY 13 Activity Plan – NPM 02

National Performance Measure 02: <i>Percent of Children with Special Health Care Needs (0-18 yrs) whose families partner in decision making at all levels and are satisfied with services they receive.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Promote and support family input and partnership in decision making at state, local, and individual levels of service planning and delivery.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: 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.</p>				X
<p>Activity 2: Monitor CYSHCN family satisfaction with CSHCN SP contractor services.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review contractor quarterly reports and QA site monitoring visits.</p>				X
<p>Activity 3: Review and evaluate CYSHCN needs and satisfaction pertaining to health care benefits and state service systems as reported by available data.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Satisfaction assessment efforts, progress, barriers, and results.</p>				X

Title V FY 13 Activity Plan – NPM 03

National Performance Measure 03: <i>Percent of Children with Special Health Care Needs age 0-18 who receives coordinated, ongoing, comprehensive care within a medical home.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>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.</p> <p><u>Output Measure(s):</u> 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.</p> <p><u>Monitoring:</u> 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.</p>				X
<p>Activity 2: CSHCN SP regional staff and contractors help CYSHCN access medical homes and integrated dental and mental/behavioral health services.</p> <p><u>Output Measure(s):</u> 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.</p> <p><u>Monitoring:</u> Review regional activity and contractor quarterly reports, DSHS training module completion certificates submitted by contractors.</p>		X		

Title V FY 13 Activity Plan – NPM 03

National Performance Measure 03: <i>Percent of Children with Special Health Care Needs age 0-18 who receives coordinated, ongoing, comprehensive care within a medical home.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>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.</p> <p><u>Output Measure(s):</u> 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.</p> <p><u>Monitoring:</u> Review of medical home projects and other initiatives; activity and data reports.</p>				X

Title V FY 13 Activity Plan – NPM 04

National Performance Measure 04: <i>Percent of Children with Special Health Care Needs age 0-18 whose families have adequate private or public insurance to pay for the services they need.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: 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.</p>				X
<p>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.</p> <p><u>Output Measure(s)</u>: 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 CYSHCN 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.</p> <p><u>Monitoring</u>: Review monthly CSHCN SP health care benefits client and provider data from TMHP and program quarterly data summary reports.</p>	X	X	X	X
<p>Activity 3: Provide information to families, providers, and others on paying for health care for CYSHCN.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review contractor quarterly reports, program publications, and other means of communication.</p>			X	

Title V FY 13 Activity Plan – NPM 05

National Performance Measure 05: Percent of Children with Special Health Care Needs age 0-18 whose families report the community-based systems are organized so they can use them easily.	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review quarterly 2-1-1 and other reports and collaborative efforts.</p>				X
<p>Activity 2: Participate in agency and community efforts to assess and improve state policies, programs, and activities impacting CYSHCN families.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review stakeholder meeting records, contractor quarterly reports, publications, annual Title V Activity Plan, and DSHS training module data.</p>				X
<p>Activity 3: Promote use of "People-First" language and appropriate languages, literacy levels, and cultural approaches in all communications regarding CYSHCN families.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review media, staff activities, DSHS training module completion data, contractor technical assistance, Quality Assurance (QA) site visits, communications, and quarterly reports.</p>			X	

Title V FY 13 Activity Plan – NPM 05

National Performance Measure 05: <i>Percent of Children with Special Health Care Needs age 0-18 whose families report the community-based systems are organized so they can use them easily.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 4: Provide and monitor comprehensive case management, family supports, and community resources through the CSHCN SP.</p> <p><u>Output Measure(s)</u>: Number of CYSHCN receiving case management, family supports and community resources from contractors, regional staff, and health care benefits; QA activities.</p> <p><u>Monitoring</u>: 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.</p>		X		
<p>Activity 5: Promote collaboration, training, education, and professional development opportunities related to the Title V performance measures for providers, clients, families and others.</p> <p><u>Output Measure(s)</u>: Contractor information sharing during contractor conference calls to promote innovation and best practice; technical assistance and training provided for relevant groups.</p> <p><u>Monitoring</u>: Review contractor conference call minutes, training, education, technical assistance efforts, and resource development.</p>				X



Electronic Medical Record-based Transition Planning Tool for Children & Youth with Special Health Care Needs: Provider Uptake, Satisfaction and Transition Awareness

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BACKGROUND

The majority of Children and Youth with Special Health Care Needs (CYSHCN) survive into adulthood. Methods to improve their survival, however, have not been matched by methods to maintain their care and quality of life as they transition from pediatric to adult-based care. Many medical professionals who care for CYSHCN are ill-prepared to partner with these patients/families to help plan this transition. Transition tools have been proposed to improve this planning but there has been limited input from providers regarding the implementation of and satisfaction with the tools.

PURPOSE

To evaluate provider use, HCT knowledge and satisfaction with an electronic medical record (EMR) based Transition Planning Tool (TPT).

TRANSITION PLANNING TOOL (TPT)

- An EMR-based readiness tool designed to identify and help rectify patients' gaps in knowledge and skills about their disease and its management, as they approach transition from pediatric to adult-based health care.
- Skills, in the form of questions, are divided by age groups: 11-13, 14-16, and 17+. A subset of questions used with a parent/caregiver when the patient was developmentally unable to participate.
- Providers encouraged to ask at least one question per clinic visit. The patient's response to the question was scored. When the patient was unable to master the content, a suggested learning assignment was presented to promote skill development.
- A summary page tracks patient performance.

METHODS

TPT Implementation

- Subjects: Eligible providers were those working with CYSHCN patients, ages 11-25, in one of 13 Texas Children's Hospital (TCH) specialty clinics.
- Providers were oriented and credentialed to use the TPT.
- Technical assistance was provided upon request.
- Provider group meetings were held periodically for questions and input.

Provider Satisfaction

- Providers participating in implementation of the TPT invited to participate in satisfaction study.
- Written, informed consent was obtained.
- Surveys were administered 12 months after provider began to use the TPT.
- All protocols were approved by the Baylor College of Medicine (BCM) IRB.

METHODS (continued)

Provider Satisfaction (continued)

- Following a review of literature and discussions with providers, a survey regarding satisfaction with the TPT was developed. Responses to the survey were on a 5-point scale from "very satisfied" to "very dissatisfied."
 - A second survey adapted from Family Voices' "Family-Centered Care Self-Assessment Tool" (2008) prompted providers to self-report:
 - knowledge and use of transition topics prior to and after participation in the study;
 - usability of and satisfaction with the TPT;
 - barriers to use; and
 - suggestions for improvement
- Providers responded on a 4-point scale from "never" to "always." For purposes of analysis, "most of the time" and "always" were combined as well as "never" and "some of the time."
- Both surveys were pilot-tested with 4 additional providers.

PROVIDER DEMOGRAPHICS

Table 1: Demographic Characteristics of Providers

Characteristic		N=30
Gender	Female	27
	Male	3
Discipline	Physician	11
	Nurse Practitioner	6
	Nurse	3
	Social Worker	3
	Registered Dietitian	3
	Child Life Specialist	2
Graduation Year	Quality of Life Specialist	2
	1970-1979	4
	1980-1989	4
	1990-1999	6
	2000 - 2010	16

RESULTS: TPT IMPLEMENTATION

- 30 providers credentialed in the use of the TPT in 13 clinics: Adolescent Medicine, Allergy & Immunology, Diabetes & Endocrinology, Gastroenterology, Gynecology, Multiple Sclerosis, Muscular Dystrophy, Renal Dialysis, Retrovirology, Rheumatology, Sickle Cell, Special Needs and Spina Bifida.
- 82% of providers used the TPT.
- 92% of the TPT users reported wanting to use the TPT more often.
- 88% agreed that a reminder would help them increase their use of the TPT.
- There were 103 communications from providers to the team asking for assistance.
- Retrovirology providers were especially enthusiastic about their participation due to the importance of transition for their patients; this became a Quality Improvement project for the service.
- The TPT formalized the transition planning process.

RESULTS: PROVIDER SATISFACTION

Table 2: Provider Self-Assessment N = 30

Question	Looking back, prior to starting to use the transition template, how often did you:		Since starting to use the transition template, how often do you:		P-value*
	Always/Most of the time	Never/Some of the time	Always/Most of the time	Never/Some of the time	
Understand the needs of patients transitioning into adulthood?	50%	50%	87%	13%	0.001
Offer the patient the opportunity to be interviewed without parents or guardians present?	37%	63%	62%	38%	0.016
Ensure the patient is knowledgeable about their diagnosis and current treatments?	67%	33%	90%	10%	0.016
Help the patient learn about self management of their health?	53%	47%	100%	0%	n/a
Discuss with the patient eventually seeing an adult care physician or other adult health care provider?	30%	70%	73%	27%	<0.001
Talk to families and patients about their vision for the future (Education, dreams, meaningful work, social relationships, and financials)?	53%	47%	73%	27%	0.109
Confirm that the patient can discuss their diagnosis with an adult care provider?	20%	80%	53%	47%	0.006
Help the family and patient develop a formal healthcare transition plan?	17%	83%	50%	50%	0.002
Assist in helping families plan for support if the patient will be unable to independently manage their care?	30%	70%	37%	63%	0.625

*McNemar statistical test

For additional information:

- Email the TRACS™ project manager at tracs@texaschildrens.org
- Baylor College of Medicine's 13th Annual Chronic Illness and Disability Transition from Pediatric to Adult-based Care Conference in October 2012 <http://baylorcme.org>

Supported by the Office of Title V & Family Health, Texas Department of State Health Services, using Title V Maternal and Child Health Services Block Grant Funds, grant no. 2011-036449-001; and the Maternal and Child Health Bureau, Baylor College of Medicine Leadership Education in Adolescent Health Training Program, grant no. 2531202316.

RESULTS: PROVIDER SATISFACTION (continued)

Table 3: Provider Satisfaction with the TPT
 N=25 (5 providers did not use the TPT)

How satisfied are you with:	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
The ease of using the tool?	32.0%	52.0%	8.0%	4.0%	4.0%
The flow between the questions, answers, and action buttons?	44.0%	32.0%	20.0%	0.0%	4.0%
The tool summary page helping you to follow a patient through the transition process?	36.0%	40.0%	12.0%	8.0%	4.0%
The time it takes to utilize the tool in clinic?	33.0%	25.0%	21.0%	17.0%	4.0%
The training you were given prior to using the tool?	60.0%	24.0%	4.0%	8.0%	4.0%
Technical assistance or troubleshooting in using the tool?	48.0%	12.0%	40.0%	0.0%	0.0%
The reliability of printing documents in the tool?	52.0%	16.0%	32.0%	0.0%	0.0%
The accessibility of the tool?	52.0%	20.0%	8.0%	16.0%	4.0%
The educational materials (e.g. Worksheets) and resource lists (e.g. Adult Resource List) provided through the yellow boxes in the tool?	44.0%	32.0%	20.0%	4.0%	0.0%

LIMITATIONS

- This study is confined to one pediatric hospital.
- Subjects are a select group of motivated early adopters.

CONCLUSIONS

- With limited prompting and technical assistance, the majority of providers used or desired increased use of the TPT.
- The majority of providers improved their self-assessed transition planning knowledge and skills despite limited use of the TPT.
- The TPT is perceived by providers as being usable, yet unless transition planning is made a higher priority, manifest as improved technical assistance in the use of the TPT, the barriers (e.g. time, accessibility, remembering to use) to TPT implementation will remain.



Impact of an Electronic Medical Record-based Transition Planning Tool on Health Care Transition Planning and Patient/Family Perception of this Planning for Children & Youth with Special Health Care Needs

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BACKGROUND

- In the United States, there are 12 million children and youth with special health care needs (CYSHCN). 500,000 reach age 21 annually.
- To meet the needs of CYSHCN at Texas Children's Hospital (TCH) the Maternal and Child Health Bureau funded-Baylor College of Medicine (BCM) LEAH developed an electronic medical record-based Transition Planning Tool (TPT).

PURPOSE

To evaluate the impact of the TPT on health care transition (HCT) planning as measured by (1) patient/family perception and (2) medical record documentation of HCT planning.

TRANSITION PLANNING TOOL (TPT)

- An education tool (developed with input from TCH family and teen advisory boards) designed to facilitate transition planning over the course of several years.
- Providers oriented and credentialed to use the TPT. Study staff available for technical assistance. Providers responsible for remembering to use the TPT when patient returned to clinic.
- Knowledge and skills needed for successful transition assessed using 30 questions, developed from literature.
- Questions divided into age groups: 11-13, 14-16 and ≥ 17 years of age. A subset of questions used with the parent/caregiver when the patient is unable to participate.
- Providers encouraged to ask at least one question per clinic visit. The patient's response to the question was scored. When the patient was unable to master the content, a suggested learning assignment was presented.
- A status page indicates which questions were mastered and which remain to be mastered.
- TPT includes a succinct portable medical record summary given to the patient at their last pediatric visit. The patient is instructed to deliver it to their adult care provider.

METHODS

- Longitudinal study design
- Eligibility criteria: CYSHCN aged 11-25 years; English speaking; at least one appointment in the previous year and expected to be seen at least once in the upcoming year; and, no prior exposure to the TPT.
- The parent/caregiver of a minor patient expected to participate. Those of an adult patient encouraged to participate with the patient's permission.
- Screening and recruiting plan developed for each clinic in study.
- Patient/parent/caregivers recruited by the patient's provider.
- Written, informed consent approved by the BCM IRB.
- Interviews with patient/family, before exposure to the TPT (baseline) and 12 months after first exposure, to elicit impact of the illness/disability, and experience/perception of transition planning.

For additional information:

- Email the TRACS™ project manager at tracs@texaschildrens.org
 - Baylor College of Medicine's 13th Annual Chronic Illness and Disability Transition from Pediatric to Adult-based Care Conference in October 2012 <http://cme.bcm.tmc.edu>, (713)798-8237
- Supported by the Office of Title V & Family Health, Texas Department of State Health Services, using Title V Maternal and Child Health Services Block Grant Funds; and the Maternal and Child Health Bureau, Baylor College of Medicine LEAH, grant no. 2531202316.

METHODS (continued)

- Subjects to answer independently, without discussion
- Interview questions read out loud by research coordinator
- Chart reviews:
 - 12 months before and after initial exposure to the TPT
 - Expert consensus used to determine what language indicated a transition topic was addressed
 - Coding manual developed and chart reviewers trained
 - Inter-rater reliability monitored
- Patient/family interview and chart review data collection forms developed from the NS-CSHCN 2005/2006 and to include components of the core transition outcome (CTO) (Lotstein 2009):
Did the CYSHCN's healthcare provider:
 - discuss shifting to adult providers,
 - discuss adult health care needs,
 - discuss health insurance,
 - usually or always encourages the child to take responsibility for his or her care.
- In order to meet the CTO, all 4 components must be achieved.**

STUDY SAMPLE

Table 1: Patient Demographic Characteristics

Characteristic		N=146
Gender	Female	49%
Age	11 - 13 years	23%
	14 - 16 years	43%
	17 - 23 years	34%
Race/Ethnicity	Black/African American	46%
	White	22%
	Hispanic	19%
	Other	6%
	Chose not to answer	7%
Family Income	\$0 - \$20,000	21%
	\$20,001 - \$40,000	13%
	\$40,001 - \$60,000	11%
	\$60,001 +	26%
	Don't Know	13%
	Chose not to answer	16%

Table 2: Severity of Patient Illness

How often does the condition affect the child doing age appropriate things?	Never	29%
	Sometimes	42%
	Usually/Always	21%
	Don't Know	8%
Rate the severity of the difficulties caused by the child's health problems.	No Difficulties	24%
	Minor Difficulties	35%
	Moderate Difficulties	33%
	Severe Difficulties	9%
How many school days missed due to illness?	0 Days	21%
	1 - 10 days	20%
	More than 10 days	15%
	Did not go to school	7%
	Home Schooled	7%
	Don't Know	30%

Table 3: Number of Patients Recruited per Clinic

Adolescent Medicine & Gynecology	3
Allergy & Immunology	7
Diabetes/Endocrine	18
Gastroenterology	19
Muscular Dystrophy	13
Multiple Sclerosis	12
Renal Dialysis	12
Retrovirology	30
Rheumatology	5
Sickle Cell	14
Special Needs	4
Spina Bifida	9

RESULTS

Provider Use of TPT

- 71% of patients (104/146) were exposed to the TPT
- Number of questions asked per patient:
 - 1-3 = 14%
 - 4-8 = 29%
 - ≥9 = 57%

Table 4: Patient/Family Responses to the Four Components of the Core Transition Outcome (CTO)

	Patient N=91			Family N = 75		
	Baseline	Follow-up	McNemar P-Value	Baseline	Follow-Up	McNemar P-Value
Provider talked about patient eventually seeing providers who treat adults.	53%	74%	0.146	48%	81%	<0.001
Provider discussed patient's healthcare needs as an adult.	69%	71%	0.481	57%	77%	0.004
Provider discussed changes in insurance as patient reaches adulthood.	18%	36%	0.013	17%	41%	0.002
How often does provider encourage patient to take responsibility for their health care needs?	93%	96%	0.625	98%	92%	0.453
Met all 4 components of the CTO.	12%	28%	0.250	10%	21%	0.008

* N equals the number of patients/families who have completed the baseline and follow-up interviews

Table 5: Medical Record Review of the Four Components of the Core Transition Outcome

Outcome Component	Baseline Yes	Follow-Up Yes	McNemar P-Value
Evidence of a discussion about seeing an adult doctor	0%	11%	N/A
Evidence of a discussion about future adult health care needs	0%	6%	N/A
Evidence of a discussion about adult health insurance	1%	28%	<0.001
Evidence the provider is encouraging the patient to take responsibility for their own health care	21%	22%	0.775

Table 6: Patient Perception of the Transition Process N-97

Question	Baseline		Follow-Up		McNemar P-Value
	Agree	Disagree	Agree	Disagree	
Providers allow patient to make decisions about health care.	70%	30%	63%	37%	0.678
Providers help patient prepare for move to adult services.	67%	33%	72%	28%	0.189
Providers allow patient to be seen alone in clinic.	70%	30%	74%	26%	0.405
Providers help patient plan for future.	75%	25%	76%	24%	0.481
Providers help to support patient's independence.	77%	23%	85%	15%	0.180
Providers understand being a child or parent of a child with chronic illness or disability.	83%	17%	83%	17%	0.815

* N equals the number of patients/families who have completed the baseline and follow-up interviews

RESULTS (continued)

Table 7: Family Perception of the Transition Process N=75

Question	Baseline		Follow-Up		McNemar P-Value
	Agree	Disagree	Agree	Disagree	
Providers allow patient to make decisions about health care.	76%	24%	69%	31%	0.701
Providers help patient prepare for move to adult services.	68%	32%	77%	23%	0.523
Providers allow patient to be seen alone in clinic.	65%	35%	61%	39%	0.541
Providers help patient plan for future.	69%	31%	75%	25%	0.442
Providers help to support patient's independence.	88%	12%	87%	4%	1.000
Providers understand being a child or parent of a child with chronic illness or disability.	90%	10%	88%	12%	0.774

* N equals the number of patients/families who have completed the baseline and follow-up interviews

LIMITATIONS

- Small study sample
- Lack of comparison group
- Reliance on patient/family report and chart documentation may not adequately capture provider-patient interaction during the office visit.

CONCLUSIONS

- In contrast to Lotstein's results (41%), the minority of parents reported reaching the CTO.
- With minimal technical support, the TPT had a significant impact on meeting the CTO as reported by patients and families.
- Similarly provider self assessment of transition knowledge and skills improved with little technical support. (Hergenroeder 2012a*).
- In contrast, using chart documentation, no patient achieved all 4 components of the CTO.
- Transition planning is happening but infrequently being documented.
- Discussions with providers about insurance occur in a minority of cases.
- The majority of patients and families perceive that their providers are encouraging patient independence and planning for future adult health care.

* Electronic Medical Record-based Transition Planning Tool for Children & Youth with Special Health Care Needs: Provider Uptake, Satisfaction and Transition Awareness, companion poster, PAS-SPR 2012 conference

IMPLICATIONS

- The families and patients' perceptions of planning for future health care must now be coupled with concrete, tangible steps to actual transfer of care to adult practices.
- As physicians are not prepared to discuss insurance, that subject should be addressed by other health care team members.
- The urgency of planning future health insurance will depend upon the outcome of the U.S. Supreme Court's ruling on the Affordability Care Act.

Title V FY 13 Activity Plan – NPM 06

National Performance Measure 06: <i>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.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Provide transition case management for CYSHCN through CSHCN SP regional staff and contractors.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review transition training data; quarterly regional and contractor case management reports.</p>		X		
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review progress and results reports.</p>				X
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review meeting minutes, publications, and progress reports, including contractor reports.</p>				X

Title V FY 13 Activity Plan – NPM 06

National Performance Measure 06: <i>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.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review resource information shared, trainings developed, meeting minutes, stakeholder meeting records, and reports of other collaborative efforts.</p>				X

Title V FY 13 Activity Plan – NPM 07

National Performance Measure 07: <i>Percent of 19-35 month olds who have received full schedule of age appropriate immunizations against MMR, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus, Influenza, and Hepatitis B.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.</p> <p><u>Output Measure(s)</u>: Number and types of partnerships; summary report on efforts undertaken; current initiatives and outcomes or expectations.</p> <p><u>Monitoring</u>: Track the number and type of partnership activities.</p>				X
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Track number and type of activities, including quarterly Health Service Region reports; documentation on materials produced.</p>			X	

Title V FY 13 Activity Plan – NPM 08

National Performance Measure 08: <i>The rate of birth (per 1,000) for teenagers aged 15 through 17 years.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Coordinate educational and awareness activities to increase understanding of teen pregnancy prevention, including disparities (racial/ethnic, geographic) in rates.</p> <p><u>Output Measure(s)</u>: 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; number of teen pregnancy prevention activities provided through the Texas School Health Network (TSHN).</p> <p><u>Monitoring</u>: Copy of materials or products distributed; summary of annual events; review quarterly progress reports.</p>			X	
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review meeting notes; quarterly progress reports.</p>				X
<p>Activity 3: Implement Texas Healthy Adolescent Initiative in local communities.</p> <p><u>Output Measure(s)</u>: Number of contractors; number and type of activities conducted by contractor.</p> <p><u>Monitoring</u>: Documentation of materials and plans developed; monthly progress reports.</p>				X

Title V FY 13 Activity Plan – NPM 09

National Performance Measure 09: <i>Percent of third grade children who have received protective sealants on at least one permanent molar tooth</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Continue providing dental sealants to Texas school children.</p> <p><u>Output Measure(s)</u>: Number of children who receive dental sealants.</p> <p><u>Monitoring</u>: Track progress of the data collection, analysis and reporting.</p>	X			
<p>Activity 2: Monitor data on the number and percent of third graders with untreated caries.</p> <p><u>Output Measure(s)</u>: Summary of representative sampling data from regional dentists and other entities.</p> <p><u>Monitoring</u>: Analyze, interpret and report on data collected.</p>				X
<p>Activity 3: Increase access to preventive dental care services through school-based efforts.</p> <p><u>Output Measure(s)</u>: Number of screenings provided, referrals made, and children with access to dental services through school-based health centers.</p> <p><u>Monitoring</u>: Analyze, interpret, and report on data collected, review quarterly progress reports.</p>				X
<p>Activity 4: Collaborate with stakeholders to develop oral health promotion activities and materials for providers and recipients of services.</p> <p><u>Output Measure(s)</u>: Number and type of stakeholders involved in developing activities; number and type of materials developed; number and type of activities coordinated by regional staff.</p> <p><u>Monitoring</u>: Review of materials developed and distributed, review of quarterly progress reports.</p>			X	

Title V FY 13 Activity Plan – NPM 10

National Performance Measure 10: <i>The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Distribute child safety seats to low-income families via educational classes throughout the state.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Maintain a current list of participating organizations; track the number of seats distributed to the organizations on an ongoing basis.</p>			X	
<p>Activity 2: Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: 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.</p>				X
<p>Activity 3: Conduct traffic safety presentations throughout the state and health service regions.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Track progress of presentations conducted (per calendar year); quarterly progress reports from regional staff.</p>			X	

Title V FY 13 Activity Plan – NPM 10

National Performance Measure 10: <i>The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 4: Review of report on child deaths resulting from motor vehicle crashes and develop policy recommendations and activities aimed at reducing such deaths.</p> <p>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.</p> <p>Monitoring: Updates on child deaths, prevention and training activities, and potential recommendations at quarterly State Child Fatality Review Team Committee meetings.</p>				X

Title V FY 13 Activity Plan – NPM 11

National Performance Measure 11: <i>The percent of mothers who breastfeed their infants at 6 months of age.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Develop promotion and support of breastfeeding in the community.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review progress toward completion of report.</p>			X	X
<p>Activity 2: Develop promotion and support for breastfeeding in health care systems.</p> <p><u>Output Measure(s)</u>: Completed health services report including indicators related to birth facility support and information, education, and communication for health services.</p> <p><u>Monitoring</u>: Review progress toward completion of report.</p>			X	X
<p>Activity 3: Develop promotion and support for breastfeeding in the workplace.</p> <p><u>Output Measure(s)</u>: Completed workplace report including indicators related to increasing support for breastfeeding in the workplace through population based activities and infrastructure building activities.</p> <p><u>Monitoring</u>: Review progress toward completion of report.</p>			X	X
<p>Activity 4: Increase integration of breastfeeding promotion and support into DSHS programs.</p> <p><u>Output Measure(s)</u>: Number and types of activities implemented within DSHS from the DSHS Infant Feeding Strategic Plan.</p> <p><u>Monitoring</u>: Document progress toward implementation of strategic plan.</p>				X

Title V FY 13 Activity Plan – NPM 12

National Performance Measure 12: <i>Percentage of newborns who have been screened for hearing before hospital discharge.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria.</p> <p><u>Output Measure(s)</u>: Number of compliant and noncompliant programs that report newborn hearing data to DSHS.</p> <p><u>Monitoring</u>: Document the results through monthly reports generated by the newborn hearing electronic monitoring system developed for this project.</p>				X
<p>Activity 2: Evaluation of the TEHDI program utilizing system data to manage the program.</p> <p><u>Output Measure(s)</u>: Number and percent of infants screened before hospital discharge, 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.</p> <p><u>Monitoring</u>: Review of system data utilizing quarterly reports generated by the hearing management information system.</p>				X
<p>Activity 3: Collaborate with multiple stakeholders to develop and disseminate educational materials for providers and parents.</p> <p><u>Output Measure(s)</u>: Number and type of stakeholders involved in activities, type and number of materials developed and disseminated, number of stakeholder meetings held.</p> <p><u>Monitoring</u>: Documentation of meetings held and number of educational materials distributed; Review THSteps CE module completion records.</p>			X	
<p>Activity 4: Provide training, outreach, and technical assistance to hospitals and medical home providers.</p> <p><u>Output Measure(s)</u>: Type and number of trainings delivered, number of new providers utilizing the hearing management information system and technical assistance provided.</p> <p><u>Monitoring</u>: Review of the quarterly reports generated by the electronic hearing management information system and other TEHDI databases developed.</p>				X

Title V FY 13 Activity Plan – NPM 13

National Performance Measure 13: <i>Percent of children without health insurance.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Monitor and report the percentage of children without health insurance.</p> <p><u>Output Measure(s)</u>: Percent of children without health insurance.</p> <p><u>Monitoring</u>: Follow progress in developing periodic child health insurance status report.</p>				X
<p>Activity 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.</p> <p><u>Output Measure(s)</u>: Percentage of children without health insurance who are enrolled into CHIP and other state-funded insurance programs as identified by Title V contractors.</p> <p><u>Monitoring</u>: Periodic quality assurance reviews of contractors.</p>			X	X
<p>Activity 3: Identify and develop partnerships with internal and external stakeholders to increase children’s access to insurance.</p> <p><u>Output Measure(s)</u>: Number and types of partnerships and trainings, activities, and resources developed/distributed; summary report on collaborative efforts undertaken.</p> <p><u>Monitoring</u>: Track the number and type of partnerships, trainings, and activities; documentation of materials created and/or distributed; review of Health Service Region reports.</p>			X	X

Title V FY 13 Activity Plan – NPM 14

National Performance Measure 14: <i>Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review quarterly WIC performance measure data on nutrition education contacts.</p>			X	
<p>Activity 2: Study food purchase patterns in WIC families.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Track quarterly progress.</p>				X
<p>Activity 3: Conduct outreach to inform potentially eligible persons about the benefits and availability of the WIC Program.</p> <p><u>Output Measure(s)</u>: Type and number of activities included; Track percentage of potentially eligible participants serve by the WIC program.</p> <p><u>Monitoring</u>: Track progress on activities. Track potential eligible participants biannually.</p>				X

Title V FY 13 Activity Plan – NPM 15

National Performance Measure 15: <i>Percent of women who smoke in the last three months of pregnancy.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Support statewide tobacco prevention and cessation efforts that target men and women of childbearing age and their families.</p> <p><u>Output Measure(s)</u>: Reports detailing media campaign impact; number of calls to Quitline resulting from activities; other activities that promote tobacco prevention and cessation.</p> <p><u>Monitoring</u>: Track activity progress and development of reports; review quarterly Health Service Region reports.</p>			X	
<p>Activity 2: Monitor smoking rates in the last three months of pregnancy among adults and teens by race and ethnicity.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review birth record, PRAMS, and Texas BRFSS data as available.</p>				X
<p>Activity 3: Develop, implement, promote, and evaluate training for promotores/community health workers to provide smoking cessation interventions during pregnancy.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: 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.</p>			X	

Title V FY 13 Activity Plan – NPM 16

National Performance Measure 16: <i>The rate (per 100,000) of suicide deaths among youths aged 15 through 19.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Broaden the public’s awareness of youth suicide, its risk factors, and prevention.</p> <p><u>Output Measure(s)</u>: Maintain Website for suicide prevention information and resources; number of public awareness activities.</p> <p><u>Monitoring</u>: Document updates for the website regarding suicide information and prevention; document public awareness activities.</p>			X	
<p>Activity 2: Provide training to individuals, communities, and schools to identify and refer youth at higher risk of suicide and suicide attempts.</p> <p><u>Output Measure(s)</u>: 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)).</p> <p><u>Monitoring</u>: Documentation of suicide prevention best practice trainings completed.</p>			X	X
<p>Activity 3: Provide support to internal and external stakeholders addressing suicide prevention.</p> <p><u>Output Measure(s)</u>: Participate in the Texas Suicide Prevention Council; Obtain information about the Suicide Prevention Coalitions established statewide; number of regional activities.</p> <p><u>Monitoring</u>: 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.</p>				X

Title V FY 13 Activity Plan – NPM 16

National Performance Measure 16: <i>The rate (per 100,000) of suicide deaths among youths aged 15 through 19.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 4: Report on suicide deaths of 15-17 year olds and CFRT activities to promote suicide prevention.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: 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.</p>				X

Title V FY 13 Activity Plan – NPM 17

National Performance Measure 17: <i>Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 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.</p> <p><u>Output Measure(s)</u>: Number and type of contacts with internal and external partners regarding the standardization.</p> <p><u>Monitoring</u>: Document communication.</p>				X
<p>Activity 2: Update map of level III neonatal intensive care unit (NICU) hospitals in Texas and develop a promotion and distribution plan for sharing with partners.</p> <p><u>Output Measure(s)</u>: Updated map of level III NICU hospital locations; promotion and distribution plan.</p> <p><u>Monitoring</u>: Document communication, promotion, and distribution.</p>				X
<p>Activity 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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: 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.</p>				X

Title V FY 13 Activity Plan – NPM 18

National Performance Measure 18: <i>Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Increase infrastructure for improving access to prenatal care.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Document strategies.</p>				X
<p>Activity 2: Monitor percent of infants born to women who received early and adequate prenatal care through the analysis of previously collected surveillance data.</p> <p><u>Output Measure(s)</u>: Percent of infants born to women who received early and adequate prenatal care.</p> <p><u>Monitoring</u>: Review birth record and PRAMS data.</p>				X
<p>Activity 3: Increase DSHS engagement in preconception and interconception health.</p> <p><u>Output Measure(s)</u>: Number of partners and initiatives DSHS participates in pertaining to preconception and interconception health.</p> <p><u>Monitoring</u>: Document efforts with partners and document initiatives DSHS is involved with pertaining to preconception and interconception health.</p>				X

Title V FY 13 Activity Plan – SPM 01

State Performance Measure 01: <i>Change in percentage of CYSHCN living in congregate care settings as percent of base year 2003.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review quarterly regional activity and contractor quarterly reports, and data from the HHSC Permanency Planning and FBA Report.</p>		X		
<p>Activity 2: Fund and promote respite and other family support services through contracts, CSHCN SP health care benefits, and collaboration with other entities.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review quarterly reports from the CSHCN SP health care benefits database and contractor quarterly reports.</p>		X		
<p>Activity 3: Collaborate with public and private entities to promote permanency planning, natural supports, family-based living options, and community inclusion for CYSHCN who reside in or are at risk of placement in congregate care settings.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review Stakeholder Meeting Records on relevant meetings attended by CSHCN SP staff, contractor quarterly reports, and reports of other activities.</p>			X	



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Title V FY 13 Activity Plan – SPM 02

State Performance Measure 02: <i>Rate of excess feto-infant mortality in Texas.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Identify excess feto-infant mortality using the Perinatal Periods of Risk (PPOR) map.</p> <p><u>Output Measure(s)</u>: PPOR map developed for Texas.</p> <p><u>Monitoring</u>: PPOR map.</p>				X
<p>Activity 2: Complete analyses to identify and prioritize factors with greatest contribution to feto-infant death disparities.</p> <p><u>Output Measure(s)</u>: Number and type of analyses completed; method for prioritization identified; report of identified prioritized factors developed.</p> <p><u>Monitoring</u>: Document analyses and priorities.</p>				X
<p>Activity 3: Communicate findings of PPOR analyses to stakeholders.</p> <p><u>Output Measure(s)</u>: Communications developed; communications disseminated; number and types of stakeholders; number and types of feedback received.</p> <p><u>Monitoring</u>: Document communication and feedback received.</p>				X
<p>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.</p> <p><u>Output Measure(s)</u>: Public awareness, educational materials, and activities developed; dissemination methods identified; materials and information disseminated.</p> <p><u>Monitoring</u>: Document materials, activities, and dissemination methods; review quarterly Health Service Region reports.</p>			X	X

Title V FY 13 Activity Plan – SPM 03

State Performance Measure 03: <i>The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Assess current level at which programs are working to enhance statewide capacity to address mental and behavioral health for MCH population.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review of annual survey results.</p>				X
<p>Activity 2: Develop cross divisional opportunities for programs to increase capacity in addressing mental and behavioral health in MCH populations.</p> <p><u>Output Measure(s)</u>: Number of cross divisional partnerships; number and type of activities implemented.</p> <p><u>Monitoring</u>: Summary of partnerships and activities.</p>				X
<p>Activity 3: Partner with internal and external partners to enhance and incorporate mental and behavioral health for MCH populations into their efforts.</p> <p><u>Output Measure(s)</u>: Number of meetings and types of partners engaged; number and type of activities implemented.</p> <p><u>Monitoring</u>: Document meetings or plans developed with partners.</p>				X
<p>Activity 4: Increase opportunities to enhance and improve the quality of the data sources related to mental and behavioral health.</p> <p><u>Output Measure(s)</u>: Number of data sources that collect information about mental and behavioral health.</p> <p><u>Monitoring</u>: Use of data in reports, grants, and other documents; review quarterly Health Service Region reports.</p>				X

Title V FY 13 Activity Plan – SPM 04

State Performance Measure 04: <i>The percent of women between the ages of 18 and 44 who are current cigarette smokers.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Provide tobacco cessation resources and support to partners working on efforts to improve maternal and child health.</p> <p><u>Output Measure(s)</u>: Number of trainings held; number of resources distributed; number of referrals to Quitline by partners.</p> <p><u>Monitoring</u>: Quarterly total of training sessions held; resources distributed; and Quitline referrals made.</p>			X	
<p>Activity 2: Distribute cessation and secondhand smoke educational materials through Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Centers.</p> <p><u>Output Measure(s)</u>: Number and type of materials distributed. <u>Monitoring</u>: Number of materials distributed and the number of hits to yesquit.org website.</p> <p><u>Monitoring</u>: Number of materials distributed and the number of hits to yesquit.org website.</p>			X	
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review birth record, PRAMS, and Texas BRFSS data as available.</p>				X

Title V FY 13 Activity Plan – SPM 05

State Performance Measure 05: <i>The percent of obesity among school-aged children (grades 3-12).</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Monthly meetings to review study progress and outline dissemination activities.</p>				X
<p>Activity 2: Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent school-aged childhood obesity.</p> <p><u>Output Measure(s)</u>: Number and type of activities implemented. <u>Monitoring</u>: Quarterly review of implemented activities and overall progress.</p> <p><u>Monitoring</u>: Quarterly review of implemented activities and overall progress.</p>				X
<p>Activity 3: Disseminate information and resources about the prevalence and risk factors associated with school-aged childhood obesity.</p> <p><u>Output Measure(s)</u>: Number, type, and format of materials provided.</p> <p><u>Monitoring</u>: Quarterly review of information and resources distributed.</p>			X	
<p>Activity 4: Coordinate and implement regional and local childhood obesity prevention activities.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Review quarterly Education Service Center progress reports; review quarterly Health Service Region reports.</p>			X	

Title V FY 13 Activity Plan – SPM 06

State Performance Measure 06: <i>Rate of preventable child deaths (0-17 years old) in Texas.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 1: Expand Child Fatality Review (CFR) to cover more children in Texas to increase the understanding of risk and protective factors.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Quarterly review of number of teams and percentage of children living in counties with CFR; review quarterly Health Service Region reports.</p>				X
<p>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.</p> <p><u>Output Measure(s)</u>: 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.</p> <p><u>Monitoring</u>: Quarterly review of data submitted shared with Data Quality Workgroup and SCFRT; data collection and quality issues addressed with teams in quarterly reports.</p>				X
<p>Activity 3: Organize and facilitate internal and external stakeholders to address prevention of child drowning deaths.</p> <p><u>Output Measure(s)</u>: Number of contacts made with local coalitions; number of meetings with drowning prevention coalitions; creation and maintenance of directory of area coalitions in Texas.</p> <p><u>Monitoring</u>: Quarterly report on progress to organize water safety coalitions and facilitate coordination of drowning prevention efforts in Texas.</p>				X

Title V FY 13 Activity Plan – SPM 06

State Performance Measure 06: <i>Rate of preventable child deaths (0-17 years old) in Texas.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>Activity 4: Organize and facilitate internal and external stakeholders to address standardization of infant death scene investigations.</p> <p>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.</p> <p>Monitoring: Quarterly report on progress to expand use of the SUIDI protocol in infant death scene investigations in Texas.</p>				X

Title V FY 13 Activity Plan – SPM 07

State Performance Measure 07: <i>The extent to which research findings and/or evidence-based practices are used to develop and improve DSHS programs serving MCH populations.</i>	MCH Pyramid Level of Services			
	DHC	ES	PBS	IB
<p>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.</p> <p><u>Output Measure(s)</u>: Number, type, and format of activities implemented.</p> <p><u>Monitoring</u>: Review of annual survey results; documentation of materials/products distributed and activities completed.</p>				X
<p>Activity 2: Increase cross-divisional opportunities to promote research findings and/or evidence-based practices in DSHS programs serving MCH populations.</p> <p><u>Output Measure(s)</u>: Number, type, and format of activities implemented.</p> <p><u>Monitoring</u>: Documentation of materials/products distributed and activities completed.</p>				X
<p>Activity 3: Partner with external and internal stakeholders to identify opportunities to incorporate research findings/evidence-based practices into programs.</p> <p><u>Output Measure(s)</u>: Number of meetings and types of partners engaged; number and type of proposals developed for implementation; number and type of activities implemented.</p> <p><u>Monitoring</u>: Review meeting notes; copy of materials/plan developed.</p>				X

FORM 2
MCH BUDGET DETAILS FOR FY2014
 [Secs. 504(d) and 505(a)(3)(4)]
STATE: TX

1.	FEDERAL ALLOCATION	\$ 31,213,037
	(Item 15a of the Application Face Sheet [SF 424])	
	Of the Federal Allocation (1 above), the amount earmarked for:	
	A. Preventive and primary care for children:	
	\$ <u>9,363,911</u> <u>30%</u>	
	Children with special health care needs:	
	B. \$ <u>9,363,911</u> <u>30%</u>	
	(If either A or B is less than 30%, a waiver request must accompany the application [Sec. 505(a)(3)])	
	C. Title V administrative costs:	
	\$ <u>3,121,303</u> <u>10%</u>	
	(The above figure cannot be more than 10% [Sec 504(d)])	
2.	UNOBLIGATED BALANCE (Item 15b of SF 424)	\$ 3,932,132
3.	STATE MCH FUNDS (Item 15c of the SF 424)	\$ 40,208,728
4.	LOCAL MCH FUNDS (Item 15d of SF 424)	\$ 0
5.	OTHER FUNDS (Item 15e of SF 424)	\$ 0
6.	PROGRAM INCOME (Item 15f of SF 424)	\$ 0
7.	TOTAL STATE FUNDS (Lines 3 through 6)	
	(Below your State's FY1989 Maintenance of Effort Amount)	
	\$ <u>40,208,728</u>	
8.	FEDERAL-STATE BLOCK GRANT PARTNERSHIP (SUBTOTAL)	\$ 75,353,897
	(Total lines 1 through 6. Same as line 15g of SF424)	
9.	OTHER FEDERAL FUNDS	
	(Funds under the control of the person responsible for the administration of the Title V program)	
	a. SPRANS: \$ <u>0</u>	
	b. SSDI: \$ <u>66,392</u>	
	c. CISS: \$ <u>0</u>	
	d. Abstinence Education: \$ <u>0</u>	
	e. Healthy Start: \$ <u>0</u>	
	f. EMSC: \$ <u>0</u>	
	g. WIC: \$ <u>522,600,572</u>	
	h. AIDS: \$ <u>0</u>	
	i. CDC: \$ <u>8,063,478</u>	
	j. Education: \$ <u>0</u>	
	k. Home Visiting: \$ <u>0</u>	
	l. Other: <u>Family Planning (T-X)</u> \$ <u>15,400,847</u>	
	Other: <u>NHSCPC/Male Involvement</u> \$ <u>625,807</u>	
10.	OTHER FEDERAL FUNDS (SUBTOTAL)	\$ 546,757,096
11.	STATE MCH BUDGET GRAND TOTAL	\$ 622,110,993
	(Partnership sub-total + Other Federal MCH Funds sub-total)	

Note that Attachment 5. A. includes the complete set of figures for Forms 2, 3, 4, and 5 as prepared by the DSHS Budget Section as of 07/02/2013.

FORM 3
STATE MCH FUNDING PROFILE
 [Secs. 505(a) and 506(a)(1-3)]
STATE: TX

	FY2009		FY2010		FY2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line 1, Form 2)</i>	\$ 34,437,266	\$ 22,940,016	\$ 34,321,224	\$ 19,164,804	\$ 33,750,193	\$ 21,139,586
2. Unobligated Balance <i>(Line 2, Form 2)</i>	\$ 10,538,576	\$ 10,538,576	\$ 11,497,250	\$ 11,497,250	\$ 15,156,420	\$ 15,156,420
3. State Funds <i>(Line 3, Form 2)</i>	\$ 51,524,933	\$ 47,579,451	\$ 54,771,851	\$ 54,771,851	\$ 50,107,518	\$ 40,208,728
4. Local MCH Funds <i>(Line 4, Form 2)</i>	\$	\$	\$	\$	\$	\$
5. Other Funds <i>(Line 5, Form 2)</i>	\$ 500,330	\$ 500,330	\$ 2,724,464	\$ 2,724,464	\$ 0	\$ 0
6. Program Income <i>(Line 6, Form 2)</i>	\$ 2,527,780	\$ 1,296,777	\$ 2,260,324	\$ 2,260,324	\$ 0	\$ 0
7. Subtotal	\$ 99,528,885	\$ 82,855,150	\$ 105,575,113	\$ 90,418,694	\$ 99,014,131	\$ 76,504,735
8. Other Federal Funds <i>(Line 10, Form 2)</i>	\$ 650,771,604	\$ 593,470,866	\$ 651,737,319	\$ 554,960,029	\$ 617,620,498	\$ 588,313,035
9. Total <i>(Line 11, Form 2)</i>	\$ 750,300,489	\$ 676,326,016	\$ 757,312,432	\$ 645,378,723	\$ 716,634,629	\$ 664,817,770

	FY2012		FY2013		FY2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line 1, Form 2)</i>	\$ 33,137,934	\$ 26,264,110	\$ 31,213,037	\$ 27,280,905	\$ 31,213,037	\$
2. Unobligated Balance <i>(Line 2, Form 2)</i>	\$ 12,610,607	\$ 12,610,607	\$ 6,873,824	\$ 6,873,824	\$ 3,932,132	\$
3. State Funds <i>(Line 3, Form 2)</i>	\$ 40,208,728	\$ 40,208,728	\$ 40,208,728	\$ 36,864,903	\$ 40,208,728	\$
4. Local MCH Funds <i>(Line 4, Form 2)</i>	\$	\$	\$	\$	\$	\$
5. Other Funds <i>(Line 5, Form 2)</i>	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
6. Program Income <i>(Line 6, Form 2)</i>	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
7. Subtotal	\$ 85,957,269	\$ 79,083,445	\$ 78,295,589	\$ 71,019,631	\$ 75,353,897	\$ 0
8. Other Federal Funds <i>(Line 10, Form 2)</i>	\$ 586,853,205	\$ 546,960,482	\$ 546,908,699	\$ 344,216,722	\$ 546,757,096	\$ 0
9. Total <i>(Line 11, Form 2)</i>	\$ 672,810,474	\$ 626,043,927	\$ 625,204,288	\$ 415,236,353	\$ 622,110,993	\$ 0

Note that Attachment 5. A. includes the complete set of figures for Forms 2, 3, 4, and 5 as prepared by the DSHS Budget Section as of 07/02/2013.

FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I); AND SOURCES OF OTHER FEDERAL FUNDS (II)
[Sec. 506(2)(2)(iv)]
STATE: TX

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
Pregnant Women	\$ 7,512,182	\$ 6,253,691	\$ 4,783,601	\$ 4,096,865	\$ 4,673,672	\$ 3,611,182
b. Infants < 1 year old	\$ 83,829	\$ 69,785	\$ 48,462	\$ 41,505	\$ 69,573	\$ 53,757
c. Children 1 to 22 years old	\$ 22,402,238	\$ 18,649,268	\$ 21,683,681	\$ 18,570,760	\$ 24,695,236	\$ 19,081,140
d. CSHCN	\$ 50,933,788	\$ 42,401,024	\$ 56,831,433	\$ 48,672,682	\$ 49,115,003	\$ 37,949,435
e. All Others	\$ 11,455,934	\$ 9,536,761	\$ 15,360,427	\$ 13,155,276	\$ 15,717,369	\$ 12,144,258
f. Administration	\$ 7,140,916	\$ 5,944,622	\$ 6,867,508	\$ 5,881,605	\$ 4,743,278	\$ 3,664,964
g. SUB-TOTAL	\$ 99,528,885	\$ 82,855,150	\$ 105,575,113	\$ 90,418,694	\$ 99,014,130	\$ 76,504,734
II. Other Federal Funds						
a. SPRANS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
b. SSDI	\$ 93,390	\$ 45,928	\$ 146,770	\$ 110,361	\$ 149,879	\$ 125,666
c. CISS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
d. Abstinence Education	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
e. Healthy Start	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
f. EMSC	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
g. WIC	\$ 626,194,623	\$ 570,259,737	\$ 626,194,622	\$ 531,716,251	\$ 589,972,249	\$ 561,816,289
h. AIDS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
i. CDC	\$ 8,265,037	\$ 7,943,474	\$ 8,700,753	\$ 7,994,354	\$ 9,070,535	\$ 8,717,867
j. Education	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
k. Home Visiting						
l. Other: Family Planning (T-X)	\$ 15,492,230	\$ 14,535,005	\$ 15,976,467	\$ 14,529,849	\$ 17,680,526	\$ 16,977,711
Other: NHSCPC	\$ 726,324	\$ 686,722	\$ 718,707	\$ 609,214	\$ 747,309	\$ 675,502
III. SUB-TOTAL	\$ 650,771,604	\$ 593,470,866	\$ 651,737,319	\$ 554,960,029	\$ 617,620,498	\$ 588,313,035

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	\$ 12,780,687	\$ 11,758,642	\$ 7,419,599	\$ 6,730,100	\$ 11,204,109	\$
b. Infants < 1 year old	\$ 159,387	\$ 146,641	\$ 70,567	\$ 64,009	\$ 139,725	\$
c. Children 1 to 22 years old	\$ 20,628,819	\$ 18,979,175	\$ 32,158,043	\$ 29,169,618	\$ 18,084,124	\$
d. CSHCN	\$ 39,359,764	\$ 36,212,246	\$ 33,993,732	\$ 30,834,717	\$ 34,504,489	\$
e. All Others	\$ 8,311,485	\$ 7,646,832	\$ 1,675,275	\$ 1,519,593	\$ 7,286,210	\$
f. Administration	\$ 4,717,127	\$ 4,339,908	\$ 2,978,373	\$ 2,701,595	\$ 4,135,240	\$
g. SUB-TOTAL	\$ 85,957,269	\$ 79,083,445	\$ 78,295,589	\$ 71,019,631	\$ 75,353,897	\$ 0
II. Other Federal Funds						
a. SPRANS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
b. SSDI	\$ 74,835	\$ 43,237	\$ 66,392	\$ 44,333	\$ 66,392	\$
c. CISS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
d. Abstinence Education	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
e. Healthy Start	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
f. EMSC	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
g. WIC	\$ 561,224,835	\$ 522,378,715	\$ 522,600,572	\$ 209,666,162	\$ 522,600,572	\$
h. AIDS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
i. CDC	\$ 8,695,515	\$ 7,951,905	\$ 8,063,797	\$ 6,904,331	\$ 8,063,478	\$
j. Education	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
k. Home Visiting						
l. Other: Family Planning (T-X)	\$ 16,059,276	\$ 15,847,798	\$ 15,400,847	\$ 127,037,078	\$ 15,400,847	\$
Other: NHSCPC/Male Involvement	\$ 798,744	\$ 738,827	\$ 777,091	\$ 564,818	\$ 625,807	\$
III. SUB-TOTAL	\$ 586,853,205	\$ 546,960,482	\$ 546,908,699	\$ 344,216,722	\$ 546,757,096	\$ 0

Note that Attachment 5. A. includes the complete set of figures for Forms 2, 3, 4, and 5 as prepared by the DSHS Budget Section as of 07/02/2013.

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES
 [Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]
STATE: TX

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN)	\$ 71,978,395	\$ 59,920,100	\$ 79,051,442	\$ 67,702,774	\$ 55,693,920	\$ 43,032,732
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management and Coordination with Medicaid, WIC, and Education)	\$ 5,899,031	\$ 4,910,786	\$ 5,842,781	\$ 5,003,988	\$ 6,258,464	\$ 4,835,695
III. Population Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education)	\$ 13,496,724	\$ 11,235,664	\$ 10,569,566	\$ 9,052,194	\$ 9,823,218	\$ 7,590,055
IV. InfrastructureBuilding Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems)	\$ 8,154,735	\$ 6,788,601	\$ 10,111,324	\$ 8,659,737	\$ 27,238,529	\$ 21,046,254
V. Total Federal-State Title V Block Grant Partnership Total	\$ 99,528,885	\$ 82,855,150	\$ 105,575,113	\$ 90,418,694	\$ 99,014,131	\$ 76,504,735

(Federal-State Partnership only. Item 15g of the SF424. For the "Budgeted" columns this is the same figure that appears in Line 8, Form 2 and in the "Budgeted" columns of Line 7, Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3)

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN)	\$ 40,951,550	\$ 37,676,741	\$ 35,771,942	\$ 32,447,679	\$ 35,899,919	\$ 0
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management and Coordination with Medicaid, WIC, and Education)	\$ 5,565,128	\$ 5,120,096	\$ 6,535,714	\$ 5,928,355	\$ 4,878,634	\$ 0
III. Population Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education)	\$ 17,526,253	\$ 16,124,715	\$ 18,995,883	\$ 17,230,608	\$ 15,364,279	\$ 0
IV. InfrastructureBuilding Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems)	\$ 21,914,337	\$ 20,161,894	\$ 16,992,049	\$ 15,412,989	\$ 19,211,065	\$ 0
V. Total Federal-State Title V Block Grant Partnership Total	\$ 85,957,269	\$ 79,083,445	\$ 78,295,589	\$ 71,019,631	\$ 75,353,897	\$ 0

(Federal-State Partnership only. Item 15g of the SF424. For the "Budgeted" columns this is the same figure that appears in Line 8, Form 2 and in the "Budgeted" columns of Line 7, Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3)

**Texas FY14 Title V Block Grant Application
Acronyms Glossary**

Acronym	Name
2-1-1	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.
ADRC	Aging and Disability Resource Center -- Serve as single points of entry into the long-term supports and services system for people with disabilities and older adults.
AMCHP	Association of Maternal and Child Health Programs --A national resource, partner, and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.
BRFSS	Behavioral Risk Factor Surveillance System --a federally-funded telephone survey of randomly selected Texas adults (18 years of age and older) to collect data on lifestyle risk factors that contribute to leading causes of death and chronic diseases.
CFRT	Child Fatality Review Team --CFRTs are multi-disciplinary and multi-agency groups of professionals who volunteer to regularly review child (under 18 years of age) deaths in a specified geographic area to understand safety risks for children and reduce the number of preventable child deaths.
CHIP	Children's Health Insurance Program --Federally known as the State Children's Health Insurance Program.
CHS	Community Health Services Section (in FCHS) --Coordinates development of program policies and procedures for community health services programs (Titles V, X, XV, XX, and XIX; Breast and Cervical Cancer Services; Family Planning; Maternal and Child Health Care Fee for Service; Epilepsy; Primary Health Care; and County Indigent Health Care) and reviews and approves quality assurance plans, and strategies for monitoring service delivery to improve access to community-based care.
CHW	Community Health Worker (Promotora) --A trained peer from within communities, CHWs/ promotores(as) provide outreach, health education, and referrals to local community members.
CPS	Child Protective Services (DFPS) --Child Protective Services Division of the Department of Family and Protective Services investigates reports of abuse and neglect of children.
CRCGs	Community Resource Coordinating Groups --Are local interagency groups comprised of public and private agency representatives whose participants develop service plans for individuals and families whose needs require more intensive interagency service coordination and cooperation.
CSHCN SP	Children with Special Health Care Needs Services Program (in PHSU) --DSHS program that provides health benefits to qualified children with special health care needs and their families, and individuals of all ages with cystic fibrosis.
CYSHCN	Children and Youth with Special Health Care Needs --Those who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions who require health and related services of a type or amount beyond that required by children and youth generally.
DADS	Department of Aging and Disability Services --Administers long-term services and supports for people who are aging and who have cognitive and physical disabilities.
DARS	Department of Assistive and Rehabilitative Services --Administers programs supporting people with disabilities and children with developmental delays.
DFPS	Department of Family and Protective Services --Administers programs protecting children and adults who are elderly or have disabilities and licenses group day-care homes, day-care centers, and registered family homes.
DSHS	Department of State Health Services --Administers programs to improve the physical and behavioral health of all Texans.

**Texas FY14 Title V Block Grant Application
Acronyms Glossary**

Acronym	Name
EBT	Electronic Benefits Transfer --EBT uses a smart card with an embedded microchip that contains WIC participants' benefits that clients can use to obtain food at a grocery store.
ECI	Early Childhood Intervention Services (DARS) --provides comprehensive early intervention services to families with infants and toddlers who have developmental delays, have diagnosed physical or mental conditions with a high probability of developmental delay, or exhibit atypical development.
ESC	Education Service Center --Provides professional development for teachers and education administrators in areas such as technology, bilingual education, special education, and programs reducing students' at-risk behaviors.
FCHS	Family and Community Health Services (DSHS) --This Division has three Sections: Specialized Health, Nutrition Services, and Community Health Service as well as the Office of Title V & Family Health which administers the Title V Block Grant for Texas, and the Office of Program Decision Support, which includes the Title V subject matter experts and is responsible for the data analysis for Title V performance measures are also located within FCHS.
FQHC	Federally Qualified Health Centers --Community-based, non-profit or public entity health care clinics charged with providing comprehensive primary health care services to individuals who are underserved, underinsured, and/or uninsured.
FSS	Family Support Services --Services provided by CSHCN SP such as home/vehicle modifications, caregiver training, and special equipment and supplies that help clients be more independent and able to take part in family and community activities.
HCCT	Healthy Child Care Texas --State initiative that 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.
HHSC	Health and Human Services Commission --Oversees the Texas health and human services system (including DSHS, DADS, DARS, and DFPS) and directly administers Medicaid and CHIP among other health and human services programs.
HHS	Health and Human Services System --Texas health and human services system includes five agencies (HHSC, DSHS, DFPS, DARS, DADS) which operate under the oversight of the Health and Human Services Commission.
HSCMU	Health Screening and Case Management Unit (in Specialized Health Services Section of FCHS) --Administers federally mandated preventive health services, including dental care, for 0-21 year-olds on Medicaid and mandated screening programs, including vision/hearing and genetics, and case management services.
HSR	Health Service Region --Geographic designations for Texas health and human service delivery areas.
HTB	Healthy Texas Babies Initiative --The Healthy Texas Babies 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.
ICC	Interagency Coordinating Council for Building Healthy Families --Facilitates communication and collaboration concerning policies for the prevention of and early intervention in child abuse and neglect among state agencies (HHSC, DSHS, DFPS, DADS, DARS, Texas Youth Commission, TEA, Texas Workforce Commission TWC, Office of the Attorney General, Texas Juvenile Probation Commission, and Texas Department of Housing and Community Affairs) whose programs and services promote and foster healthy families.
LAR	Legislative Appropriations Request --In Texas, each agency or institution prepares a budget request (LAR) that outlines their funding requirements and needs for the next two years.

**Texas FY14 Title V Block Grant Application
Acronyms Glossary**

Acronym	Name
LBB	Legislative Budget Board -- A 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.
LEAH	Leadership and Education in Adolescent Health Program --LEAH works through grants to states to improve the health and well-being of adolescents through education, research, program and service model development, evaluation, and dissemination of best practices.
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV Home Visiting) --A program that facilitates collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.
MHSA	Mental Health and Substance Abuse Division (DSHS) --Has three sections that administer community health and substance abuse programs, state hospital operations, and community mental health and substance abuse contracts.
MHWG	Medical Home Workgroup -- Workgroup comprised of family members of CYSHCN, representatives from community organizations, state agencies and family advocacy organizations, community physicians, and other health care providers, strives to enhance the development of Medical Homes within the primary care setting.
MTP	Medical Transportation Program --An HHSC program providing non-emergency medical transportation services to eligible Medicaid and CSHCN SP clients who do not have other means to access medically necessary services.
NBSU	Newborn Screening Unit (in Specialized Health Services Section of FCHS) -- Oversees testing, follow-up, and case management resulting from screening all newborns in Texas for 28 inheritable and other disorders.
NCQA	National Committee for Quality Assurance --A private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. NCQA Patient-Centered Medical Home standards describe clear and specific criteria, for patient care.
NS-CSHCN	National Survey of Children with Special Health Care Needs --This survey, sponsored by HRSA's MCHB and carried out by the Centers for Disease Control and Prevention's National Center for Health Statistics, provides detailed information on the prevalence of CSHCN in the Nation and in each State, the demographic characteristics of these children, the types of health and support services they and their families need, and their access to and satisfaction with the care they receive.
OHP	Oral Health Program --DSHS program that provides preventive dental health education and services.
OPCCY	Office of Program Coordination for Children and Youth (HHSC) --Assists in coordinating programs and initiatives that serve children and youth across health and human service systems (i.e., CRCGs, TIFI, early childhood coordination, children's mental health, children's long term care).
OPDS	Office of Program Decision Support (in FCHS) --Provides support in the areas of research design, program evaluation, data analysis, and MCH subject matter experts.
OTV&FH	Office of Title V & Family Health (in FCHS) --Provides oversight and administration of Title V-funded activities, the Community Health Worker Certification and Training Program, and the Texas Primary Care Office.
PCP	Primary care provider --A health care professional who helps in identifying or preventing or treating illness or disability.
PHSU	Purchased Health Services Unit (in Specialized Health Services Section of FCHS) --Administers health care benefits and services under the CSHCN Services Program, provides medical expertise and consultation to providers of services for CYSHCN, administers adult client services programs for persons with end stage renal disease and oversees eligibility determination, enrollment services, third party billing, and provider reimbursement.

**Texas FY14 Title V Block Grant Application
Acronyms Glossary**

Acronym	Name
PMU	Performance Management Unit (in CHS of FCHS) --Develops and manages contracts for all CHS programs, including those that are Title V-funded . See CHS for listing of programs.
PPCU	Preventive and Primary Care Unit (in CHS of FCHS) --Develops and implements 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.
PRAMS	Pregnancy Risk Assessment Monitoring System --Joint Texas and CDC surveillance project that monitors maternal attitudes and behaviors before, during and after pregnancy.
RFP	Request for Proposals --An early stage in a contract procurement process , issuing an invitation for organizations or suppliers, often through a bidding process, to submit a proposal on a specific service or commodity.
RPE	Rape Prevention and Education --DSHS contract with the Texas Office of the Attorney General's Sexual Assault Prevention and Crisis Services Program to implement the CDC Rape Prevention and Education grant to support the primary prevention of sexual assault and/or violence.
SBHC	School Based Health Center --A program that provides access to health care services to school-age children delivering primary and preventive health servies and related social services on a school campus.
SCFRT	State Child Fatality Review Team --A statutorily-defined multidisciplinary group of professionals led by DSHS MCH staff who review the data collected statewide to develop position statements and make recommendations to the Texas Legislature and Governor for changes in law, policy, and practice to reduce the number of preventable child deaths.
SHS	Specialized Health Services Section (in FCHS) --Consists of three Units: the Purchased Health Services Unit (PHSU), the Health Screening and Case Management Unit (HSCMU), and the Newborn Screening Unit (NBSU).
SIDS	Sudden Infant Death Syndrome --Unexplained death, usually during sleep, of a seemingly healthy baby.
SSDI	State Systems Development Initiative --HRSA/MCHB grant to states to assist State MCH and CSHCN programs in the building of State and community infrastructure that results in comprehensive, community-based systems of care for all children and their families through data integration (i.e., Title V, WIC, Breast and Cervical Cancer Services, and other MCH-related programs).
SSI	Supplemental Security Income --Government program administered by the Social Security Administration that provides stipends to low-income persons who are either aged (65 or older), blind, or disabled.
STARMHAC	Statewide Association for Regional Medical Home Advancement --A HRSA-funded project to build a statewide infrastructure for maternal and child health in the six critical systems outcomes.
TCDD	Texas Council for Developmental Disabilities --One of 56 state councils on developmental disabilities in the USA and its territories. The Council works to ensure that people with disabilities have services and supports needed for full participation in community life.
TEA	Texas Education Agency --State agency that provides leadership, guidance, and resources to help Texas schools meet the educational needs of all students.
TEXT4BABY	Text4baby --A free mobile information service designed to promote maternal and child health. An educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB), text4baby provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life.

**Texas FY14 Title V Block Grant Application
Acronyms Glossary**

Acronym	Name
THAI	Texas Healthy Adolescent Initiative --A DSHS-developed program incorporating comprehensive, evidence-based youth development approaches to increase healthy behaviors and decision-making among Texas adolescents.
THSteps	Texas Health Steps --The name adopted in Texas for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) federal Medicaid program for children.
TISWG	Texas Immunization Stakeholder Working Group --Work group to increase partnerships across the state to raise vaccine coverage levels and improve immunization practices for all Texans.
TxP2P	Texas Parent to Parent --Nonprofit organization created by parents for families of children with disabilities, chronic illness, and other special needs throughout the state of Texas.
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children (in FCHS) --Provides nutrition education, food supplements, and referrals for health and social services for pregnant, breastfeeding, and postpartum women, infants, and children under age five who are at nutritional risk.
YRBSS	Texas Youth Risk Behavior Surveillance System --a federally-funded classroom based paper survey conducted to track health-risk behaviors and social problems among youth (age 12-18).

TITLE V BLOCK GRANT APPLICATION
FORMS (2-21)
STATE: TX
APPLICATION YEAR: 2014

- [**FORM 2 - MCH BUDGET DETAILS**](#)
- [**FORM 3 - STATE MCH FUNDING PROFILE**](#)
- [**FORM 4 - BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED AND SOURCES OF FEDERAL FUNDS**](#)
- [**FORM 5 - STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES**](#)
- [**FORM 6 - NUMBER AND PERCENTAGE OF NEWBORN AND OTHERS SCREENED, CASE CONFIRMED, AND TREATED**](#)
- [**FORM 7 - NUMBER OF INDIVIDUALS SERVED \(UNDUPLICATED\) UNDER TITLE V**](#)
- [**FORM 8 - DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX**](#)
- [**FORM 9 - STATE MCH TOLL-FREE TELEPHONE LINE DATA**](#)
- [**FORM 10 - TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT STATE PROFILE FOR FY 2013**](#)
- [**FORM 11 - NATIONAL AND STATE PERFORMANCE MEASURES**](#)
- [**FORM 12 - NATIONAL AND STATE OUTCOME MEASURES**](#)
- [**FORM 13 - CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CHILDREN WITH SPECIAL HEALTH CARE NEEDS**](#)
- [**FORM 14 - LIST OF MCH PRIORITY NEEDS**](#)
- [**FORM 15 - TECHNICAL ASSISTANCE \(TA\) REQUEST AND TRACKING**](#)
- [**FORM 16 - STATE PERFORMANCE/OUTCOME MEASURE DETAIL SHEETS**](#)
- [**FORM 17 - HEALTH SYSTEM CAPACITY INDICATORS \(01 THROUGH 04,07,08\) - MULTI-YEAR DATA**](#)
- **FORM 18**
 - [**MEDICAID AND NON-MEDICAID COMPARISON**](#)
 - [**MEDICAID ELIGIBILITY LEVEL \(HSCI 06\)**](#)
 - [**SCHIP ELIGIBILITY LEVEL \(HSCI 06\)**](#)
- **FORM 19**
 - [**GENERAL MCH DATA CAPACITY \(HSCI 09A\)**](#)
 - [**ADOLESCENT TOBACCO USE DATA CAPACITY \(HSCI 09B\)**](#)
- [**FORM 20 - HEALTH STATUS INDICATORS 01-05 - MULTI-YEAR DATA**](#)
- **FORM 21**
 - [**POPULATION DEMOGRAPHICS DATA \(HSI 06\)**](#)
 - [**LIVE BIRTH DEMOGRAPHICS DATA \(HSI 07\)**](#)
 - [**INFANT AND CHILDREN MORTALITY DATA \(HSI 08\)**](#)
 - [**MISCELLANEOUS DEMOGRAPHICS DATA \(HSI 09\)**](#)
 - [**GEOGRAPHIC LIVING AREA DEMOGRAPHIC DATA \(HSI 10\)**](#)
 - [**POVERTY LEVEL DEMOGRAPHIC DATA \(HSI 11\)**](#)
 - [**POVERTY LEVEL FOR CHILDREN DEMOGRAPHICS DATA \(HSI 12\)**](#)

FORM 2
MCH BUDGET DETAILS FOR FY 2014
[Secs. 504 (d) and 505(a)(3)(4)]
STATE: TX

1. FEDERAL ALLOCATION

(Item 15a of the Application Face Sheet [SF 424])

Of the Federal Allocation (1 above), the amount earmarked for:

\$ 31,213,037

A.Preventive and primary care for children:

\$ 9,363,911 (30 %)

B.Children with special health care needs:

\$ 9,363,911 (30 %)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V administrative costs:

\$ 3,121,303 (10 %)

(The above figure cannot be more than 10%)[Sec. 504(d)]

2. UNOBLIGATED BALANCE (Item 15b of SF 424)

\$ 3,932,132

3. STATE MCH FUNDS (Item 15c of the SF 424)

\$ 40,208,728

4. LOCAL MCH FUNDS (Item 15d of SF 424)

\$ 0

5. OTHER FUNDS (Item 15e of SF 424)

\$ 0

6. PROGRAM INCOME (Item 15f of SF 424)

\$ 0

7. TOTAL STATE MATCH (Lines 3 through 6)

(Below is your State's FY 1989 Maintenance of Effort Amount)

\$ 40,208,728

\$ 40,208,728

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL)

(Total lines 1 through 6. Same as line 15g of SF 424)

\$ 75,353,897

9. OTHER FEDERAL FUNDS

(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS: \$ 0

b. SSDI: \$ 66,392

c. CISS: \$ 0

d. Abstinence Education: \$ 0

e. Healthy Start: \$ 0

f. EMSC: \$ 0

g. WIC: \$ 522,600,572

h. AIDS: \$ 0

i. CDC: \$ 8,063,478

j. Education: \$ 0

k. Home Visiting: \$ 0

l. Other: \$ 0

FamilyPlanning (T-X) \$ 15,400,847

NHSCPC/MaleInvolve \$ 625,807

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9)

\$ 546,757,096

11. STATE MCH BUDGET TOTAL

(Partnership subtotal + Other Federal MCH Funds subtotal)

\$ 622,110,993

FORM NOTES FOR FORM 2

Please note that Attachment V. A includes the complete set of Forms 2, 3, 4, and 5 as prepared by the the DSHS Budget Section to provide a complete updated set of budget and expenditure data as of June 2013.

Budgeted amounts for FY14 are estimated since the federal award may change and FY13 expenditures are not final.

FIELD LEVEL NOTES

1. **Section Number:** Form2_Main
Field Name: FedAlloc_Admin
Row Name: Federal Allocation - Title V Administrative costs
Column Name:
Year: 2014
Field Note:
Figure rounded down to \$3,121,303.

FORM 3
STATE MCH FUNDING PROFILE
[Secs. 505(a) and 506((a)-(3))]
STATE: TX

	FY 2009		FY 2010		FY 2011	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation <i>(Line1, Form 2)</i>	\$ 34,184,513	\$ 22,940,016	\$ 34,446,314	\$ 19,164,804	\$ 34,437,266	\$ 21,139,587
2. Unobligated Balance <i>(Line2, Form 2)</i>	\$ 6,141,299	\$ 10,538,576	\$ 12,894,495	\$ 11,497,250	\$ 8,580,980	\$ 15,156,420
3. State Funds <i>(Line3, Form 2)</i>	\$ 46,447,844	\$ 47,579,451	\$ 56,129,051	\$ 54,771,851	\$ 54,886,980	\$ 40,208,728
4. Local MCH Funds <i>(Line4, Form 2)</i>	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
5. Other Funds <i>(Line5, Form 2)</i>	\$ 250,000	\$ 500,330	\$ 250,000	\$ 2,724,464	\$ 250,000	\$ 0
6. Program Income <i>(Line6, Form 2)</i>	\$ 2,527,780	\$ 1,296,777	\$ 37,706	\$ 2,260,324	\$ 2,527,780	\$ 0
7. Subtotal	\$ 89,551,436	\$ 82,855,150	\$ 103,757,566	\$ 90,418,693	\$ 100,683,006	\$ 76,504,735
(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)						
8. Other Federal Funds <i>(Line10, Form 2)</i>	\$ 575,780,008	\$ 593,470,866	\$ 570,310,569	\$ 554,960,029	\$ 605,513,800	\$ 588,313,035
9. Total <i>(Line11, Form 2)</i>	\$ 665,331,444	\$ 676,326,016	\$ 674,068,135	\$ 645,378,722	\$ 706,196,806	\$ 664,817,770
(STATE MCH BUDGET TOTAL)						

FORM 3
STATE MCH FUNDING PROFILE
[Secs. 505(a) and 506((a)-(3))]
STATE: TX

	FY 2012		FY 2013		FY 2014	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation <i>(Line1, Form 2)</i>	\$ 33,678,798	\$ 26,264,110	\$ 33,750,193	\$	\$ 31,213,037	\$
2. Unobligated Balance <i>(Line2, Form 2)</i>	\$ 9,306,829	\$ 12,610,607	\$ 14,546,974	\$	\$ 3,932,132	\$
3. State Funds <i>(Line3, Form 2)</i>	\$ 46,105,185	\$ 40,208,728	\$ 40,208,728	\$	\$ 40,208,728	\$
4. Local MCH Funds <i>(Line4, Form 2)</i>	\$ 0	\$ 0	\$ 0	\$	\$ 0	\$
5. Other Funds <i>(Line5, Form 2)</i>	\$ 290,902	\$ 0	\$ 0	\$	\$ 0	\$
6. Program Income <i>(Line6, Form 2)</i>	\$ 2,527,780	\$ 0	\$ 0	\$	\$ 0	\$
7. Subtotal	\$ 91,909,494	\$ 79,083,445	\$ 88,505,895	\$ 0	\$ 75,353,897	\$ 0
(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)						
8. Other Federal Funds <i>(Line10, Form 2)</i>	\$ 626,031,673	\$ 546,960,482	\$ 554,335,767	\$	\$ 546,757,096	\$
9. Total <i>(Line11, Form 2)</i>	\$ 717,941,167	\$ 626,043,927	\$ 642,841,662	\$ 0	\$ 622,110,993	\$ 0
(STATE MCH BUDGET TOTAL)						

FORM NOTES FOR FORM 3

Please note that Attachment V. A includes the complete set of Forms 2, 3, 4, and 5 as prepared by the the DSHS Budget Section to provide a complete updated set of budget and expenditure data as of June 2013.

Budgeted amounts for FY14 are estimated since the federal award may change and FY13 expenditures are not final.

FIELD LEVEL NOTES

1. **Section Number:** Form3_Main
Field Name: FedAllocExpended
Row Name: Federal Allocation
Column Name: Expended
Year: 2012
Field Note:
07/01/2013 - Correct FY12 budgeted amount is \$33,137,934. Expended differs from budgeted amount by 21% because 100% of the unobligated balance available in 2012 was expended in 2012.
2. **Section Number:** Form3_Main
Field Name: FedAllocExpended
Row Name: Federal Allocation
Column Name: Expended
Year: 2011
Field Note:
Correct FY11 Budgeted Amount is 33,750,193. Expended differs from budgeted amount by 23% because 100% of the unobligated balance available in 2011 was expended in FY11.
3. **Section Number:** Form3_Main
Field Name: UnobligatedBalanceExpended
Row Name: Unobligated Balance
Column Name: Expended
Year: 2012
Field Note:
07/01/2013 - The updated correct FY12 budgeted amount is \$12,610,607; therefore, there is no difference in budgeted and expended.
4. **Section Number:** Form3_Main
Field Name: UnobligatedBalanceExpended
Row Name: Unobligated Balance
Column Name: Expended
Year: 2011
Field Note:
The updated correct FY11 budgeted amount is 15,156,420; therefore, there is no difference in budgeted and expended.
5. **Section Number:** Form3_Main
Field Name: StateMCHFundsExpended
Row Name: State Funds
Column Name: Expended
Year: 2012
Field Note:
07/01/2013 - The updated correct FY12 budgeted amount is \$40,208,728; therefore, there is no difference in budgeted and expended.
6. **Section Number:** Form3_Main
Field Name: StateMCHFundsExpended
Row Name: State Funds
Column Name: Expended
Year: 2011
Field Note:
The updated correct FY11 budgeted amount is 40,208,728; therefore, there is no difference in budgeted and expended.
7. **Section Number:** Form3_Main
Field Name: OtherFundsExpended
Row Name: Other Funds
Column Name: Expended
Year: 2012
Field Note:
07/01/2013 - The updated correct FY12 budgeted amount is 0; therefore, there is no difference in budgeted and expended.
8. **Section Number:** Form3_Main
Field Name: OtherFundsExpended
Row Name: Other Funds
Column Name: Expended
Year: 2011
Field Note:
The updated correct FY11 budgeted amount is 0; therefore, there is no difference in budgeted and expended.
9. **Section Number:** Form3_Main
Field Name: ProgramIncomeExpended
Row Name: Program Income
Column Name: Expended
Year: 2012

Field Note:

07/01/2013 - The updated correct FY12 budgeted amount is 0; therefore, there is no difference in budgeted and expended.

10. Section Number: Form3_Main

Field Name: ProgramIncomeExpended

Row Name: Program Income

Column Name: Expended

Year: 2011

Field Note:

The updated correct FY11 budgeted amount is 0; therefore, there is no difference in budgeted and expended.

11. Section Number: Form3_Main

Field Name: OtherFedFundsExpended

Row Name: Other Federal Funds

Column Name: Expended

Year: 2012

Field Note:

07/01/2013 - Budgeted amount is incorrect. It should be 586,853,205; however, the system will not accept change in the budgeted field. Actual expenditures were 93% of the budgeted amount.

FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: TX

	FY 2009		FY 2010		FY 2011	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	\$ 10,006,532	\$ 6,253,690	\$ 8,476,492	\$ 4,096,865	\$ 4,776,187	\$ 3,611,181
b. Infants < 1 year old	\$ 89,900	\$ 69,785	\$ 99,777	\$ 41,505	\$ 57,725	\$ 53,757
c. Children 1 to 22 years old	\$ 17,346,350	\$ 18,649,268	\$ 24,268,091	\$ 18,570,760	\$ 20,525,721	\$ 19,081,140
d. Children with Special Healthcare Needs	\$ 43,087,359	\$ 42,401,024	\$ 49,669,910	\$ 48,672,682	\$ 51,907,849	\$ 37,949,435
e. Others	\$ 12,954,783	\$ 9,536,761	\$ 14,100,275	\$ 13,155,276	\$ 16,545,619	\$ 12,144,258
f. Administration	\$ 6,066,512	\$ 5,944,622	\$ 7,143,021	\$ 5,881,605	\$ 6,869,905	\$ 3,664,964
g. SUBTOTAL	\$ 89,551,436	\$ 82,855,150	\$ 103,757,566	\$ 90,418,693	\$ 100,683,006	\$ 76,504,735
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	\$ 0		\$ 0		\$ 0	
b. SSDI	\$ 94,644		\$ 94,644		\$ 93,713	
c. CISS	\$ 0		\$ 0		\$ 0	
d. Abstinence Education	\$ 0		\$ 0		\$ 0	
e. Healthy Start	\$ 0		\$ 0		\$ 0	
f. EMSC	\$ 0		\$ 0		\$ 0	
g. WIC	\$ 553,930,301		\$ 554,091,746		\$ 581,324,119	
h. AIDS	\$ 0		\$ 0		\$ 0	
i. CDC	\$ 7,467,337		\$ 8,526,836		\$ 7,418,165	
j. Education	\$ 0		\$ 0		\$ 0	
k. Home Visiting	\$ 0		\$ 0		\$ 0	
l. Other						
FamPlanning Title X	\$		\$		\$ 15,976,467	
NHSCPC/MaleInvolve	\$		\$		\$ 701,336	
Fam Planning Title X	\$		\$ 6,896,007		\$	
NHSCPC/Male Involvem	\$		\$ 701,336		\$	
FamilyPlanning(T-X)	\$ 13,372,014		\$		\$	
NHSCPC/MaleInvolvem	\$ 915,712		\$		\$	
III. TOTAL	\$ 575,780,008		\$ 570,310,569		\$ 605,513,800	

FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)
[Secs 506(2)(2)(iv)]
STATE: TX

	FY 2012		FY 2013		FY 2014	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	\$ 3,481,486	\$ 11,758,643	\$ 8,898,022		\$ 11,204,109	
b. Infants < 1 year old	\$ 54,268	\$ 146,641	\$ 77,886		\$ 139,725	
c. Children 1 to 22 years old	\$ 20,081,460	\$ 18,979,175	\$ 23,529,960		\$ 18,084,124	
d. Children with Special Healthcare Needs	\$ 44,833,549	\$ 36,212,246	\$ 42,487,766		\$ 34,504,489	
e. Others	\$ 17,336,457	\$ 7,646,832	\$ 6,919,094		\$ 7,286,210	
f. Administration	\$ 6,122,274	\$ 4,339,908	\$ 6,593,167		\$ 4,135,240	
g. SUBTOTAL	\$ 91,909,494	\$ 79,083,445	\$ 88,505,895	\$ 0	\$ 75,353,897	\$ 0
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	\$ 0		\$ 0		\$ 0	
b. SSDI	\$ 133,669		\$ 65,357		\$ 66,392	
c. CISS	\$ 0		\$ 0		\$ 0	
d. Abstinence Education	\$ 0		\$ 0		\$ 0	
e. Healthy Start	\$ 0		\$ 0		\$ 0	
f. EMSC	\$ 0		\$ 0		\$ 0	
g. WIC	\$ 598,926,315		\$ 528,927,444		\$ 522,600,572	
h. AIDS	\$ 0		\$ 0		\$ 0	
i. CDC	\$ 8,589,827		\$ 8,582,354		\$ 8,063,478	
j. Education	\$ 0		\$ 0		\$ 0	
k. Home Visiting	\$ 0		\$ 0		\$ 0	
l. Other						
FamilyPlanning (T-X)	\$		\$		\$ 15,400,847	
NHSCPC/MaleInvolve	\$		\$		\$ 625,807	
FamilyPlan (TitleX)	\$		\$ 16,059,276		\$	
NHSCPC/Male Involvem	\$ 701,336		\$ 701,336		\$	
FamilyPlanning X	\$ 17,680,526		\$		\$	
III. TOTAL	\$ 626,031,673		\$ 554,335,767		\$ 546,757,096	

FORM NOTES FOR FORM 4

Please note that Attachment V. A includes the complete set of Forms 2, 3, 4, and 5 as prepared by the the DSHS Budget Section to provide a complete updated set of budget and expenditure data as of June 2013.

Budgeted amounts for FY14 are estimated since the federal award may change and FY13 expenditures are not final.

FIELD LEVEL NOTES

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenBudgeted
Row Name: Pregnant Women
Column Name: Budgeted
Year: 2014
Field Note:
07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).
2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenBudgeted
Row Name: Pregnant Women
Column Name: Budgeted
Year: 2013
Field Note:
Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).
3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenBudgeted
Row Name: Pregnant Women
Column Name: Budgeted
Year: 2012
Field Note:
6/24/11: Budgeted amounts for FY12 are estimated since the federal award may change and FY11 expenditures are not final.
4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenBudgeted
Row Name: Pregnant Women
Column Name: Budgeted
Year: 2011
Field Note:
Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.
5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenExpended
Row Name: Pregnant Women
Column Name: Expended
Year: 2012
Field Note:
07/02/2013 - Budgeted amount is incorrect. It should be \$12,780,687; however, the system will not accept change in the "Budgeted" field.

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.
6. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenExpended
Row Name: Pregnant Women
Column Name: Expended
Year: 2011
Field Note:
07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013. Budgeted amount should be 3,611,182.

Amount expended reflects current calculations of DSHS Budget Section as of June 2012. Budgeted amount should be 4,599,089.
7. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_0_1Budgeted
Row Name: Infants <1 year old
Column Name: Budgeted
Year: 2014
Field Note:
07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).
8. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_0_1Budgeted
Row Name: Infants <1 year old
Column Name: Budgeted
Year: 2013
Field Note:

Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).

9. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_0_1Budgeted
Row Name: Infants <1 year old
Column Name: Budgeted
Year: 2012
Field Note:
6/24/11: Budgeted amounts for FY12 are estimated since the federal award may change and FY11 expenditures are not final.
10. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_0_1Budgeted
Row Name: Infants <1 year old
Column Name: Budgeted
Year: 2011
Field Note:
Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.
11. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_0_1Expended
Row Name: Infants <1 year old
Column Name: Expended
Year: 2012
Field Note:
07/02/2013 - Budgeted amount is incorrect. It should be \$159,387; however, the system will not accept change in the "Budgeted" field.
12. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_0_1Expended
Row Name: Infants <1 year old
Column Name: Expended
Year: 2011
Field Note:
07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013. Budgeted amount should be 69,573.
13. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Budgeted
Row Name: Children 1 to 22 years old
Column Name: Budgeted
Year: 2014
Field Note:
07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).
14. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Budgeted
Row Name: Children 1 to 22 years old
Column Name: Budgeted
Year: 2013
Field Note:
Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).
15. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Budgeted
Row Name: Children 1 to 22 years old
Column Name: Budgeted
Year: 2012
Field Note:
6/24/11: Budgeted amounts for FY12 are estimated since the federal award may change and FY11 expenditures are not final.
16. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Budgeted
Row Name: Children 1 to 22 years old
Column Name: Budgeted
Year: 2011
Field Note:
Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.
17. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Expended
Row Name: Children 1 to 22 years old
Column Name: Expended
Year: 2012
Field Note:
07/02/2013 - Budgeted amount is incorrect. It should be \$20,628,819; however, the system will not accept change in the "Budgeted" field.
18. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: Children_1_22Expended
Row Name: Children 1 to 22 years old

Column Name: Expended

Year: 2011

Field Note:

07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013. Budgeted amount should be 24,695,236.

19. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: CSHCNBudgeted

Row Name: CSHCN

Column Name: Budgeted

Year: 2014

Field Note:

07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).

20. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: CSHCNBudgeted

Row Name: CSHCN

Column Name: Budgeted

Year: 2013

Field Note:

Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).

21. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: CSHCNBudgeted

Row Name: CSHCN

Column Name: Budgeted

Year: 2012

Field Note:

6/24/11: Budgeted amounts for FY12 are estimated since the federal award may change and FY11 expenditures are not final.

22. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: CSHCNBudgeted

Row Name: CSHCN

Column Name: Budgeted

Year: 2011

Field Note:

Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.

23. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: CSHCNExpended

Row Name: CSHCN

Column Name: Expended

Year: 2012

Field Note:

07/02/2013 - Budgeted amount is incorrect. It should be \$39,359,764; however, the system will not accept change in the "Budgeted" field.

24. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: CSHCNExpended

Row Name: CSHCN

Column Name: Expended

Year: 2011

Field Note:

07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013. Budgeted amount should be 49,115,003.

Amount expended reflects current calculations of DSHS Budget Section as of June 2012. Budgeted amount should be 49,294,274.

25. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AllOthersBudgeted

Row Name: All Others

Column Name: Budgeted

Year: 2014

Field Note:

07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).

26. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AllOthersBudgeted

Row Name: All Others

Column Name: Budgeted

Year: 2013

Field Note:

Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).

27. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AllOthersBudgeted

Row Name: All Others

Column Name: Budgeted

Year: 2012

Field Note:

6/24/11: Budgeted amounts for FY12 are estimated since the federal award may change and FY11 expenditures are not final.

28. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AllOthersBudgeted

Row Name: All Others

Column Name: Budgeted

Year: 2011

Field Note:

Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.

29. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AllOthersExpended

Row Name: All Others

Column Name: Expended

Year: 2012

Field Note:

07/02/2013 - Budgeted amount is incorrect. It should be \$8,311,485; however, the system will not accept change in the "Budgeted" field.

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 VMOE in the Family Planning strategy were reassigned. Funds were shifted to Pregnant Women.

30. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AllOthersExpended

Row Name: All Others

Column Name: Expended

Year: 2011

Field Note:

07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013. Budgeted amount should be 15,717,369.

Amount expended reflects current calculations of DSHS Budget Section as of June 2012. Budgeted amount should be 15,468,564.

31. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminBudgeted

Row Name: Administration

Column Name: Budgeted

Year: 2014

Field Note:

07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).

32. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminBudgeted

Row Name: Administration

Column Name: Budgeted

Year: 2013

Field Note:

Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).

33. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminBudgeted

Row Name: Administration

Column Name: Budgeted

Year: 2012

Field Note:

6/24/11: Budgeted amounts for FY12 are estimated since the federal award may change and FY11 expenditures are not final.

34. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminBudgeted

Row Name: Administration

Column Name: Budgeted

Year: 2011

Field Note:

Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.

35. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminExpended

Row Name: Administration

Column Name: Expended

Year: 2012

Field Note:

07/02/2013 - Budgeted amount is incorrect. It should be \$4,717,127; however, the system will not accept change in the "Budgeted" field.

36. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminExpended

Row Name: Administration

Column Name: Expended

Year: 2011

Field Note:

07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013. Budgeted amount should be 4,743,278.

Amount expended reflects current calculations of DSHS Budget Section as of June 2012. Budgeted amount should be 4,699,798.

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES
[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: TX

TYPE OF SERVICE	FY 2009		FY 2010		FY 2011	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	\$ 60,389,544	\$ 59,920,100	\$ 79,083,028	\$ 67,702,774	\$ 73,074,976	\$ 43,032,731
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	\$ 7,080,578	\$ 4,910,786	\$ 6,339,478	\$ 5,003,988	\$ 5,876,806	\$ 4,835,695
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	\$ 12,214,400	\$ 11,235,664	\$ 12,076,131	\$ 9,052,194	\$ 13,459,743	\$ 7,590,055
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	\$ 9,866,914	\$ 6,788,600	\$ 6,258,929	\$ 8,659,737	\$ 8,271,481	\$ 21,046,254
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	\$ 89,551,436	\$ 82,855,150	\$ 103,757,566	\$ 90,418,693	\$ 100,683,006	\$ 76,504,735

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES
[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]
STATE: TX

TYPE OF SERVICE	FY 2012		FY 2013		FY 2014	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	\$ 68,695,349	\$ 37,676,740	\$ 61,079,763	\$	\$ 35,899,919	\$
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	\$ 5,057,173	\$ 5,120,096	\$ 5,557,015	\$	\$ 4,878,634	\$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	\$ 9,142,487	\$ 16,124,715	\$ 8,558,596	\$	\$ 15,364,279	\$
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	\$ 9,014,485	\$ 20,161,894	\$ 13,310,521	\$	\$ 19,211,065	\$
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	\$ 91,909,494	\$ 79,083,445	\$ 88,505,895	\$ 0	\$ 75,353,897	\$ 0

FORM NOTES FOR FORM 5

Please note that Attachment V. A includes the complete set of Forms 2, 3, 4, and 5 as prepared by the the DSHS Budget Section to provide a complete updated set of budget and expenditure data as of June 2013.

Budgeted amounts for FY14 are estimated since the federal award may change and FY13 expenditures are not final.

FIELD LEVEL NOTES

1. **Section Number:** Form5_Main
Field Name: DirectHCBudgeted
Row Name: Direct Health Care Services
Column Name: Budgeted
Year: 2014
Field Note:
07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).
2. **Section Number:** Form5_Main
Field Name: DirectHCBudgeted
Row Name: Direct Health Care Services
Column Name: Budgeted
Year: 2013
Field Note:
Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).
3. **Section Number:** Form5_Main
Field Name: DirectHCBudgeted
Row Name: Direct Health Care Services
Column Name: Budgeted
Year: 2012
Field Note:
06/24/11: Budgeted amount for FY12 is estimated since the federal award may change in FY12 and FY11 expenditures are not final.
4. **Section Number:** Form5_Main
Field Name: DirectHCBudgeted
Row Name: Direct Health Care Services
Column Name: Budgeted
Year: 2011
Field Note:
Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.
5. **Section Number:** Form5_Main
Field Name: DirectHCExpended
Row Name: Direct Health Care Services
Column Name: Expended
Year: 2012
Field Note:
07/01/2013 - Budgeted amount is incorrect. It should be \$40,951,550; however system will not accept change in "Budgeted" field for FY12. Expenditures were 92% of budgeted amount.
6. **Section Number:** Form5_Main
Field Name: DirectHCExpended
Row Name: Direct Health Care Services
Column Name: Expended
Year: 2011
Field Note:
07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013.

Amount expended reflects current calculations of DSHS Budget Section as of June 2012.
7. **Section Number:** Form5_Main
Field Name: EnablingBudgeted
Row Name: Enabling Services
Column Name: Budgeted
Year: 2014
Field Note:
07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).
8. **Section Number:** Form5_Main
Field Name: EnablingBudgeted
Row Name: Enabling Services
Column Name: Budgeted
Year: 2013
Field Note:
Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).

9. **Section Number:** Form5_Main
Field Name: EnablingBudgeted
Row Name: Enabling Services
Column Name: Budgeted
Year: 2012
Field Note:
06/24/11: Budgeted amount for FY12 is estimated since the federal award may change in FY12 and FY11 expenditures are not final.
10. **Section Number:** Form5_Main
Field Name: EnablingBudgeted
Row Name: Enabling Services
Column Name: Budgeted
Year: 2011
Field Note:
Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.
11. **Section Number:** Form5_Main
Field Name: EnablingExpended
Row Name: Enabling Services
Column Name: Expended
Year: 2011
Field Note:
07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013.

Amount expended reflects current calculations of DSHS Budget Section as of June 2012.
12. **Section Number:** Form5_Main
Field Name: PopBasedBudgeted
Row Name: Population-Based Services
Column Name: Budgeted
Year: 2014
Field Note:
07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).
13. **Section Number:** Form5_Main
Field Name: PopBasedBudgeted
Row Name: Population-Based Services
Column Name: Budgeted
Year: 2013
Field Note:
Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).
14. **Section Number:** Form5_Main
Field Name: PopBasedBudgeted
Row Name: Population-Based Services
Column Name: Budgeted
Year: 2012
Field Note:
06/24/11: Budgeted amount for FY12 is estimated since the federal award may change in FY12 and FY11 expenditures are not final.
15. **Section Number:** Form5_Main
Field Name: PopBasedBudgeted
Row Name: Population-Based Services
Column Name: Budgeted
Year: 2011
Field Note:
Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.
16. **Section Number:** Form5_Main
Field Name: PopBasedExpended
Row Name: Population-Based Services
Column Name: Expended
Year: 2012
Field Note:
07/01/2013 - Budgeted amount is incorrect. It should be \$17,526,253; however system will not accept change in "Budgeted" field for FY12. Expenditures were 92% of budgeted amount.
17. **Section Number:** Form5_Main
Field Name: PopBasedExpended
Row Name: Population-Based Services
Column Name: Expended
Year: 2011
Field Note:
07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013.

Amount expended reflects current calculations of DSHS Budget Section as of June 2012.
18. **Section Number:** Form5_Main

Field Name: InfrastrBuildBudgeted

Row Name: Infrastructure Building Services

Column Name: Budgeted

Year: 2014

Field Note:

07/02/2013 - Budgeted amount is estimated based on current Title V federal grant award and FY13 Operating Budget developed by the DSHS Budget Section (as of June 2013).

19. Section Number: Form5_Main

Field Name: InfrastrBuildBudgeted

Row Name: Infrastructure Building Services

Column Name: Budgeted

Year: 2013

Field Note:

Budgeted amount is estimated based on current Title V federal grant award and FY12 Operating Budget developed by the DSHS Budget Section (as of June 2012).

20. Section Number: Form5_Main

Field Name: InfrastrBuildBudgeted

Row Name: Infrastructure Building Services

Column Name: Budgeted

Year: 2012

Field Note:

06/24/11: Budgeted amount for FY12 is estimated since the federal award may change in FY12 and FY11 expenditures are not final.

21. Section Number: Form5_Main

Field Name: InfrastrBuildBudgeted

Row Name: Infrastructure Building Services

Column Name: Budgeted

Year: 2011

Field Note:

Updated 7/14/10: Budgeted amount for FY11 is estimated since the federal award may change in FY11 and FY10 expenditures are not final.

22. Section Number: Form5_Main

Field Name: InfrastrBuildExpended

Row Name: Infrastructure Building Services

Column Name: Expended

Year: 2012

Field Note:

07/01/2013 - Budgeted amount is incorrect. It should be \$21,914,337; however system will not accept change in "Budgeted" field for FY12. Expenditures were 92% of budgeted amount.

23. Section Number: Form5_Main

Field Name: InfrastrBuildExpended

Row Name: Infrastructure Building Services

Column Name: Expended

Year: 2011

Field Note:

07/01/2013 - Amount expended reflects current calculations of DSHS Budget Section as of June 2013.

Amount expended reflects current calculations of DSHS Budget Section as of June 2012.

FORM 6

NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Sect. 506(a)(2)(B)(iii)

STATE: TX

Total Births by Occurrence:

Reporting Year: 2012

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria	379,341	97.3	54	10	10	100
Congenital Hypothyroidism	379,341	97.3	7,345	214	214	100
Galactosemia	379,341	97.3	176	3	3	100
Sickle Cell Disease	379,341	97.3	231	168	168	100
Other Screening (Specify)						
Biotinidase Deficiency	379,341	97.3	206	30	30	100
Cystic Fibrosis	379,341	97.3	421	68	68	100
Homocystinuria	379,341	97.3	153	3	3	100
Maple Syrup Urine Disease	379,341	97.3	97	3	3	100
beta-ketothiolase deficiency	379,341	97.3	0	0	0	
Tyrosinemia Type I	379,341	97.3	1	1	1	100
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	379,341	97.3	123	4	4	100
Argininosuccinic Acidemia	379,341	97.3	99	2	2	100
Citrullinemia	379,341	97.3	99	1	1	100
Isovaleric Acidemia	379,341	97.3	511	2	2	100
Propionic Acidemia	379,341	97.3	510	2	2	100
Camitine Uptake Defect	379,341	97.3	706	4	4	100
3-Methylcrotonyl-CoA Carboxylase Deficiency	379,341	97.3	199	17	17	100
Methylmalonic acidemia (Cbl AB)	379,341	97.3	510	7	7	100
Multiple Carboxylase Deficiency	379,341	97.3	0	0	0	
Trifunctional Protein Deficiency	379,341	97.3	0	0	0	
Glutaric Acidemia Type I	379,341	97.3	243	2	2	100
Hydroxymethylglutaric Aciduria	379,341	97.3	0	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	379,341	97.3	214	14	14	100
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	379,341	97.3	34	1	1	100

Methylmalonic Acidemia (Mutase Deficiency)	379,341	97.3	510	1	1	100
Congenital Adrenal Hyperplasia (Classical)	379,341	97.3	4,432	21	21	100
Severe Combined Immunodeficiency	30,424	7.8	390	1	1	100
Screening Programs for Older Children & Women (Specify Tests by name)						
Hearing Screening	2,577,316		40,266	0	11,651	
Vision Screening	2,651,490		219,310	0	98,249	
Spinal Screening	751,352		23,700	0	4,258	
(1) Use occurrent births as denominator.						
(2) Report only those from resident births.						
(3) Use number of confirmed cases as denominator.						

FORM NOTES FOR FORM 6

None

FIELD LEVEL NOTES

1. **Section Number:** Form6_Main
Field Name: BirthOccurence
Row Name: Total Births By Occurence
Column Name: Total Births By Occurence
Year: 2014
Field Note:
From the 2012 preliminary birth file. Data from this file are subject to change.
2. **Section Number:** Form6_Other Screening Types
Field Name: Other
Row Name: All Rows
Column Name: All Columns
Year: 2014
Field Note:
The number of presumptive cases for: Citrillinemia is redundant with Argininosuccinic Acidemia, Propionic Acidemia and Methylmalonic Acidemia are redundant with Methylmalonic Acidemia
3. **Section Number:** Form6_Screening Programs for Older Children and Women
Field Name: OtherWomen
Row Name: All Rows
Column Name: All Columns
Year: 2014
Field Note:
For these screenings we know the number of children that were referred and treated, but not the number of confirmed cases. From the school based Vision, Hearing and Spinal screening program.

FORM 7
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V
(BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: TX

Number of Individuals Served - Historical Data by Annual Report Year

Types of Individuals Served	2007	2008	2009	2010	2011
Pregnant Women	159,425	136,950	97,641	67,232	39,389
Infants < 1 year old	414,161	416,508	408,374	394,736	384,085
Children 1 to 22 years old	6,073,452	6,093,947	6,186,914	6,140,797	6,002,980
Children with Special Healthcare Needs	81,622	80,180	98,607	110,513	101,848
Others	137,412	136,855	123,886	254,649	213,866
Total	6,866,072	6,864,440	6,915,422	6,967,927	6,742,168

Reporting Year: 2012

Types of Individuals Served	PRIMARY SOURCES OF COVERAGE					
	(A) Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
Pregnant Women	37,599	0.0	0.0	0.0	0.0	100.0
Infants < 1 year old	389,901	0.0	0.0	0.0	0.0	100.0
Children 1 to 22 years old	5,144,226	0.0	0.0	0.0	0.0	100.0
Children with Special Healthcare Needs	94,619	74.0	2.0	2.0	12.6	0.0
Others	22,796	0.0	0.0	0.0	0.0	100.0
TOTAL	5,689,141					

FORM NOTES FOR FORM 7

With the exception of CSHCN, data regarding "primary source of coverage" is not gathered for MCH populations served. For all other services 0 is used to identify these unknown percentages.

In previous years, referral numbers provided by Title V were received. In 2012, this information was not available; therefore, previous years' referrals ratio was used.

FIELD LEVEL NOTES

- Section Number:** Form7_Main
Field Name: PregWomen_TS
Row Name: Pregnant Women
Column Name: Title V Total Served
Year: 2014

Field Note:

Title V is not used to pay for deliveries in Texas. Pregnant Women Served includes an estimation of clients screened by Title V and referred to other funding sources during SFY 2012. These data are from:

- the Texas Title V Fee for Service Database
- Newborn Screening, Genetics Support Group.

- Section Number:** Form7_Main
Field Name: Children_0_1_TS
Row Name: Infants <1 year of age
Column Name: Title V Total Served
Year: 2014

Field Note:

It is estimated that Title V serves all infants in Texas through either newborn genetics screening or newborn hearing screening.

- Section Number:** Form7_Main
Field Name: Children_1_22_TS
Row Name: Children 1 to 22 years of age
Column Name: Title V Total Served
Year: 2014

Field Note:

Children 1-22 years served includes an estimation of clients screened by Title V and referred to other funding sources. The following programs receiving Title V funds were included in this estimate:

- Title V MCH FFS Contractors Database
- Family Planning TMHP Vision21 AHQP Universe
- Title V-funded School Based Health Clinics Summary Tables and Insurance Status Report
- BCCS Med-IT System
- Adolescent Health Guide Distribution List
- Genetics Title V New Clients Report
- Annual Statewide Hearing, Vision and Spinal screening.

In previous years the number of Hearing and Vision screens were added together for this number. Hearing and Vision screens are administered in the same grade to roughly the same children. Therefore, this year the larger number of Hearing or Vision screens was used in this count. Spinal screens are administered to a different age group, so are still included in the total.

- Section Number:** Form7_Main
Field Name: CSHCN_TS
Row Name: Children with Special Health Care Needs
Column Name: Title V Total Served
Year: 2014

Field Note:

Percentages for the CSHCN Primary Sources of Coverage indicated on this table are derived from multiple datasets. For datasets where the coverage distribution percentages are known, those percentages are employed.

Sources: CSHCN Services Program contractor reports, DSHS regional staff case management reports, and CSHCN Management Information System.

- Section Number:** Form7_Main
Field Name: AllOthers_TS
Row Name: Others
Column Name: Title V Total Served
Year: 2014

Field Note:

Women served in Title V funded programs not included in the above categories (those 22 and older): Sources:

- BCCS Med-IT System
- Family Planning TMHP Vision21 AHQP Universe
- Newborn Screening, Genetics Support group

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX
(BY RACE AND ETHNICITY)

[Sec. 506(a)(2)(C-D)]

STATE: TX

Reporting Year: 2012

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
DELIVERIES								
Total Deliveries in State	391,596	277,670	44,813	0	0	0	0	69,113
Title V Served	15,616	13,885	465	0	0	0	0	1,266
Eligible for Title XIX	204,189	133,366	29,314	0	0	0	0	41,509
INFANTS								
Total Infants in State	397,802	285,786	46,191	0	0	0	0	65,825
Title V Served	389,901	276,400	44,491	0	0	0	0	69,010
Eligible for Title XIX	252,441	164,882	36,241	0	0	0	0	51,318

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
DELIVERIES								
Total Deliveries in State	201,603	189,993	0	0	0	0	0	189,993
Title V Served	14,495	1,121	0	0	0	0	0	1,121
Eligible for Title XIX	82,463	121,726	0	0	0	0	0	121,726
INFANTS								
Total Infants in State	198,378	199,424	0	0	0	0	0	199,424
Title V Served	200,823	189,078	0	0	0	0	0	189,078
Eligible for Title XIX	101,950	150,491	0	0	0	0	0	150,491

FORM NOTES FOR FORM 8

Data are preliminary and subject to change. In keeping with the population data, American Indian, Asian, Native Hawaiian/Pacific Islander and Mixed race individuals are included in the "Other" category and not reported separately. Zeros are inserted for all collapsed race/ethnic categories.

FIELD LEVEL NOTES

- Section Number:** Form8_I. Unduplicated Count By Race
Field Name: DeliveriesTotal_All
Row Name: Total Deliveries in State
Column Name: Total All Races
Year: 2014
Field Note:
Source: 2011 fetal death and 2012 birth files. Total deliveries include fetal deaths at ≥ 20 weeks as well as all live births. Since CY 2012 fetal death data was not available, CY 2011 data was used.
- Section Number:** Form8_I. Unduplicated Count By Race
Field Name: DeliveriesTitleV_All
Row Name: Title V Served
Column Name: Total All Races
Year: 2014
Field Note:
Source: Title VMCH FFS Contractor DB.
NOTE: Title V funds are not used to pay for deliveries in Texas. Title V Deliveries served includes women receiving Title VMCH Prenatal or Postpartum services.
- Section Number:** Form8_I. Unduplicated Count By Race
Field Name: DeliveriesTitleXIX_All
Row Name: Eligible for Title XIX
Column Name: Total All Races
Year: 2014
Field Note:
SOURCE: SFY 2012 Medicaid enrollment data from Strategic Decision Support, HHSC.
NOTE: Deliveries Eligible for Title XIX race categories partially estimated using race/ethnic proportions from the CY 2012 birth file. Medicaid deliveries are reported as the total number of unduplicated paid or partially paid fee for service (FFS/PCCM) and managed care (MMC) delivery events that occurred in SFY 2012 per patient per delivery date (date of service).
- Section Number:** Form8_I. Unduplicated Count By Race
Field Name: InfantsTotal_All
Row Name: Total Infants in State
Column Name: Total All Races
Year: 2014
Field Note:
Population data from the Texas Data Center, Office of the State Demographer. Total Infants in State race categories partially estimated using race/ethnic proportions from the CY 2012 birth file.
- Section Number:** Form8_I. Unduplicated Count By Race
Field Name: InfantsTitleV_All
Row Name: Title V Served
Column Name: Total All Races
Year: 2014
Field Note:
SOURCE: CY 2012 preliminary birth file.
NOTE: It is estimated that Title V served all infants born in TX in 2012 either through the newborn genetics screening program or the newborn hearing screening program.
- Section Number:** Form8_I. Unduplicated Count By Race
Field Name: InfantsTitleXIX_All
Row Name: Eligible for Title XIX
Column Name: Total All Races
Year: 2014
Field Note:
SOURCE: SFY 012 Medicaid Enrollment Data from Strategic Decision Support, HHSC.
NOTE: Infants Eligible for Title XIX includes only infants born in SFY 2012. Race categories partially estimated using race/ethnic proportions from the CY 2012 birth file.

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TX

	FY 2014	FY 2013	FY 2012	FY 2011	FY 2010
1. State MCH Toll-Free "Hotline" Telephone Number					
2. State MCH Toll-Free "Hotline" Name					
3. Name of Contact Person for State MCH "Hotline"					
4. Contact Person's Telephone Number					
5. Contact Person's Email					
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	0	0

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TX

	FY 2014	FY 2013	FY 2012	FY 2011	FY 2010
1. State MCH Toll-Free "Hotline" Telephone Number	2-1-1 (Texas Only)				
2. State MCH Toll-Free "Hotline" Name	2-1-1 Texas Information and Referral Network				
3. Name of Contact Person for State MCH "Hotline"	Beth Wick	Deborah Ballard	Beth Wick	Beth Wick	Beth Wick
4. Contact Person's Telephone Number	512-483-5110	(512) 483-5111	(512) 483-5110	(512) 483-5110	(512) 483-5110
5. Contact Person's Email	beth.wick@hsc.state.tx.us	deborah.ballard@hsc.state.tx.us	beth.wick@hsc.state.tx.us	beth.wick@hsc.state.tx.us	beth.wick@hsc.state.tx.us
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	241353	273198	214319

FORM NOTES FOR FORM 9

None

FIELD LEVEL NOTES**1. Section Number:** Form9_Main

Field Name: calls_2

Row Name: Number of calls received On the State MCH Hotline This reporting period

Column Name: FY

Year: 2012

Field Note:

FY 2012 data was collected on a calendar year basis.

The following information is available on the HHSC website at: <http://www.hhsc.state.tx.us/help/index.shtml> or at <https://www.211texas.org/211>.

The 2-1-1 website can be translated into more than 60 different languages using a translate button on the main page.

If you need help applying for benefits, call toll-free 2-1-1 (or 1-877-541-7905). Pick a language and then pick option 2. Staff can help you Monday to Friday, 8 a.m. to 6 p.m.

If dialing 2-1-1 directly doesn't work on your phone, you can reach us at our toll-free number (877-541-7905). To better serve you, you will be asked for a ZIP code for the area you are

seeking services. Here are a few reasons why you may need to reach us this way:

-You use video phone relay, IP relay, Captioned phone relay or TTY relay. Just use your relay option of choice to place the call.

-You do not live in Texas, but are calling about services available to Texans.

-You have to dial through a PBX system that isn't programmed to handle dialing 2-1-1 but does handle toll-free dialing.

-You live near the border of Texas, and your cell phone reaches a cell phone tower in a neighboring state.

-Your cell phone or VoIP service doesn't reach 2-1-1 directly.

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2014
[Sec. 506(a)(1)]
STATE: TX

1. State MCH Administration:
(max 2500 characters)

The Department of State Health Services (DSHS) is the state agency responsible for administration of Title V and is one of four state health and human service agencies under the oversight of the Health and Human Services Commission. Within DSHS, the Division for Family and Community Health Services is responsible for most women's and children's programs. The Division administers Newborn Screening; the Texas Early Hearing Detection and Intervention Program; Vision Screening; Spinal Screening; Genetic Services; Texas Health Steps (EPSDT) Medical, Dental, and Medical Case Management services; Children with Special Health Care Needs Services Program; Oral Health Program; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Breast and Cervical Cancer Services; Prenatal Medical and Dental Services; Child Health and Dental Services; Primary Health Care Services; County Indigent Health Care Program; and the Texas Primary Care Office.

Block Grant Funds

2. Federal Allocation (Line 1, Form 2)	\$ <input type="text" value="31,213,037"/>
3. Unobligated balance (Line 2, Form 2)	\$ <input type="text" value="3,932,132"/>
4. State Funds (Line 3, Form 2)	\$ <input type="text" value="40,208,728"/>
5. Local MCH Funds (Line 4, Form 2)	\$ <input type="text" value="0"/>
6. Other Funds (Line 5, Form 2)	\$ <input type="text" value="0"/>
7. Program Income (Line 6, Form 2)	\$ <input type="text" value="0"/>
8. Total Federal-State Partnership (Line 8, Form 2)	\$ <input type="text" value="75,353,897"/>

9. Most significant providers receiving MCH funds:

Local health departments, FQHCs
community-based organizations
universities and medical schools, school districts

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	<input type="text" value="37,599"/>
b. Infants < 1 year old	<input type="text" value="389,901"/>
c. Children 1 to 22 years old	<input type="text" value="5,144,226"/>
d. CSHCN	<input type="text" value="94,619"/>
e. Others	<input type="text" value="22,796"/>

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

For FY12, Title V continued to award nearly 200 service contracts to local health care providers through a competitive request for proposals process. In FY12, a total of 670,736 individuals received direct health care and other health-related services from Title V-funded providers and DSHS regional offices. The Title V reimbursable array of direct and enabling services can be summarized into the following preventive and primary care categories: prenatal medical and dental care, child and adolescent health care, dental care, and laboratory services. Prenatal services include a total of two initial and follow-up visits; ultrasound as indicated; nutrition education; and case management for high risk women while the client is determined eligible for CHIP Perinatal. Dental services for prenatal women were piloted with existing prenatal providers during FY12. This benefit will continue in FY13. Child/adolescent health care includes primary services for infants, well-child exams, limited acute care, nutritional visits, immunizations, and case management. Dental services for children/adolescents include periodic oral evaluation, fluoride treatments, sealants, and extraction as needed. Children with Special Health Care Needs Services Program provides primary care, specialty care, case management, and family support services for children and youth with special health care needs. A majority of laboratory testing services are provided to Title V-funded providers through DSHS laboratories.

b. Population-Based Services:
(max 2500 characters)

Title V population-based initiatives include those implemented through Title V-funded contractors targeting local communities or a group of individuals and those delivered by DSHS central and regional offices with a statewide impact including the development and distribution of educational and resource materials. The first category includes population-based contracts awarded to local entities through a competitive request for proposal process. The second category of population-based services includes projects with a statewide impact, delivered by DSHS staff from regional and central offices. A variety of educational resources are produced by DSHS staff and are distributed to the public through local providers and/or the DSHS website. All population-based projects are aligned with the purpose of essential public health services in general and that of Title V national and state performance measures in particular. Funds for these projects are used to identify and implement best practice strategies for eliminating racial, ethnic, and geographic disparities and to improve outcomes in areas such as low weight

births, adolescent health, adequacy of prenatal care, safe sleep, obesity, and injury prevention. In FY12, an estimated 5,018,405 individuals received services from Title V-funded providers and DSHS regional and central offices.

c. Infrastructure Building Services:
(max 2500 characters)

Within DSHS, Title V operates within a structure defined by eight Health Service Regions for the provision of essential health services to all Texans. Title V funds several positions based in central and regional offices to provide (1) core public health and preparedness/response services in areas with no local health department presence and (2) technical assistance, contract management, and quality assurance and improvement activities for all Title V-funded providers. Additional infrastructure building services include workforce development initiatives; data collection, research, and evaluation efforts such as Birth Defects Monitoring, PRAMS, and BRFSS; and activities which integrate program planning and implementation efforts across programs to maximize efficiencies.

12. The primary Title V Program contact person:

Name	Sam B. Cooper, III
Title	State Title V Director
Address	PO Box 149347, MC 1922
City	Austin
State	Texas
Zip	78714-9347
Phone	512/776-2184
Fax	512/776-7658
Email	samcooper@dshs.state.tx.us
Web	http://www.dshs.state.tx.us

13. The children with special health care needs (CSHCN) contact person:

Name	Manda Hall, MD
Title	State Title V CSHCN Director
Address	PO Box 149347, MC 1938
City	Austin
State	Texas
Zip	78714-9347
Phone	512/776-2567
Fax	512/776-7565
Email	manda.hall@dshs.state.tx.us
Web	http://www.dshs.state.tx.us

FORM NOTES FOR FORM 10

None

FIELD LEVEL NOTES

None

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(iii) AND 486 (a)(2)(A)(iii)]
STATE: TX

Form Level Notes for Form 11

None

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.

	<u>Annual Objective and Performance Data</u>				
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	470	524	554	571	579
Denominator	470	524	554	571	579
Data Source	Newborn Screening Database	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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

	<u>Annual Objective and Performance Data</u>				
	2013	2014	2015	2016	2017
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #1

Field Name: PM01

Row Name:

Column Name:

Year: 2012

Field Note:

Data are taken from Form 6.

2. **Section Number:** Form11_Performance Measure #1

Field Name: PM01

Row Name:

Column Name:

Year: 2011

Field Note:

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

3. **Section Number:** Form11_Performance Measure #1

Field Name: PM01

Row Name:

Column Name:

Year: 2010

Field Note:

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

PERFORMANCE MEASURE # 02

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	58	58.1	58.2	58.3	72
Annual Indicator	57.9	70.3	70.3	70.3	70.3
Numerator	450,786	639,197	639,197	639,197	639,197
Denominator	778,339	908,622	908,622	908,662	908,662
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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	72	74	74	75	75
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. Section Number: Form11_Performance Measure #2

Field Name: PM02

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come 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 mistakes.

2. Section Number: Form11_Performance Measure #2

Field Name: PM02

Row Name:

Column Name:

Year: 2011

Field Note:

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.

3. Section Number: Form11_Performance Measure #2

Field Name: PM02

Row Name:

Column Name:

Year: 2010

Field Note:

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.

PERFORMANCE MEASURE # 03

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	46.4	46.5	46.6	46.7	42
Annual Indicator	46.3	40.1	40.1	40.1	40.1
Numerator	351,768	355,285	355,285	355,285	355,285
Denominator	759,974	886,995	886,995	886,995	886,995
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. (Explain data in a year note. See Guidance, Appendix IX.)	<input type="checkbox"/>				
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	43	44	45	46	46
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. Section Number: Form11_Performance Measure #3

Field Name: PM03

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come 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 NPM3. However, the same questions were used to generate the NPM3 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 mistakes.

2. Section Number: Form11_Performance Measure #3

Field Name: PM03

Row Name:

Column Name:

Year: 2011

Field Note:

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 NPM3. However, the same questions were used to generate the NPM3 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.

3. Section Number: Form11_Performance Measure #3

Field Name: PM03

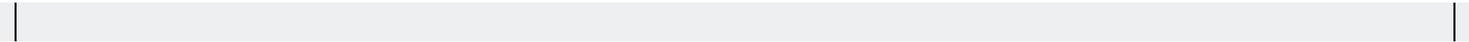
Row Name:

Column Name:

Year: 2010

Field Note:

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 NPM3 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM#03.



PERFORMANCE MEASURE # 04

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	58.3	58.4	58.5	58.6	58.7
Annual Indicator	58.2	58.0	58.0	58.0	58.0
Numerator	462,528	520,600	520,600	520,600	520,600
Denominator	795,137	898,296	898,296	898,296	898,296
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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	58.8	58.9	58.9	58.9	58.9
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. Section Number: Form11_Performance Measure #4

Field Name: PMD4

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come 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 NPM4 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 mistakes.

2. Section Number: Form11_Performance Measure #4

Field Name: PMD4

Row Name:

Column Name:

Year: 2011

Field Note:

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 NPM4 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.

3. Section Number: Form11_Performance Measure #4

Field Name: PMD4

Row Name:

Column Name:

Year: 2010

Field Note:

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.

PERFORMANCE MEASURE # 05

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	88.3	88.4	88.5	88.6	60
Annual Indicator	88.2	56.6	56.6	56.6	56.6
Numerator	706,914	515,491	515,491	515,491	515,491
Denominator	801,141	910,457	910,457	910,457	910,457
Data Source	National Survey of CSHCN	National Survey for 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	60	62	62	65	65
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come 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 mistakes.

2. Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2011

Field Note:

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.

3. Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2010

Field Note:

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.

PERFORMANCE MEASURE # 06

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	37.2	37.3	37.4	37.5	37.6
Annual Indicator	37.1	35.4	35.4	35.4	35.4
Numerator	107,424	101,253	101,253	101,253	101,253
Denominator	289,879	286,298	286,298	286,298	286,298
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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	37.7	37.8	37.9	37.9	37.9
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. Section Number: Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2012

Field Note:

For 2011-2014, indicator data come 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 NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 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 mistakes.

2. Section Number: Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2011

Field Note:

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 NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 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.

3. Section Number: Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2010

Field Note:

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.

PERFORMANCE MEASURE # 07

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	80	80	81	80	77
Annual Indicator	78.6	74.4	76.3	76.3	77.2
Numerator	431,060	412,459	430,989	418,229	416,230
Denominator	548,422	554,380	564,742	548,138	539,159
Data Source	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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	78	79	79	80	80
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2012

Field Note:

US, National Immunization Survey, 2011. The denominator is the population of 2 and 3 years olds adjusted proportionately to estimate the population of 19-36 month olds. Population numbers are from the Texas Data Center from the Office of the State Demographer.

2. **Section Number:** Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2011

Field Note:

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 2006-2011 are final.

2011 denominator based on population projections for 2011 from State Data Center of the Office of the State Demographer.

3. **Section Number:** Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2010

Field Note:

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.

PERFORMANCE MEASURE # 08

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	32	32	32	34	26
Annual Indicator	34.9	33.1	29.2	27.2	24.2
Numerator	18,934	17,907	16,015	14,015	13,150
Denominator	542,343	540,995	547,814	515,779	544,040
Data Source	Nativity 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	24	24	23.5	23.5	22
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator is from the 2012 birth file. 2012 birth data are preliminary and subject to change. Denominator is the 2012 projected population from Texas State Data Center of the Office of the State Demographer.

2. **Section Number:** Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2011

Field Note:

2011 birth data are provisional and will be finalized Aug 2013.

2011 population data are based on population estimates from Texas Data Center of the Office of the Texas State Demographer.

3. **Section Number:** Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2010

Field Note:

Update June 2012: Natality data for 2010 is finalized.

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

PERFORMANCE MEASURE # 09

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	34.4	37	37	37	37
Annual Indicator	34.4	34.4	34.4	34.4	34.4
Numerator	122,241	126,694	129,149	130,514	131,074
Denominator	355,351	368,296	375,432	379,400	381,029
Data Source	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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	37	37	39	39	39
Annual Indicator					
Numerator					
Denominator					

Field Level Notes**1. Section Number:** Form11_Performance Measure #9**Field Name:** PM09**Row Name:****Column Name:****Year:** 2012**Field Note:**

The oral health sealant data is collected only once every 5 years. The last completed data collection was in 2007-2008. Texas is currently collecting data for school year 2013. The 2012 enrollment figure was not available at time of reporting. Enrollment is estimated based on the percentage of 8 and 9 year olds in the population enrolled in 3rd grade for 2011.

2. Section Number: Form11_Performance Measure #9**Field Name:** PM09**Row Name:****Column Name:****Year:** 2011**Field Note:**

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.

3. Section Number: Form11_Performance Measure #9**Field Name:** PM09**Row Name:****Column Name:****Year:** 2010**Field Note:**

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.

PERFORMANCE MEASURE # 10

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	4.7	4.7	4.6	4	2.8
Annual Indicator	3.5	3.4	3.0	2.8	3.6
Numerator	188	187	173	156	207
Denominator	5,384,151	5,449,069	5,738,590	5,608,144	5,788,478

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	Mortality Data
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Check this box if you cannot report the numerator because
 1. There are fewer than 5 events over the last year, and
 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.
 (Explain data in a year note. See Guidance, Appendix IX.)

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Is the Data Provisional or Final?

Provisional Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	2.8	2.7	2.7	2.6	2.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10

Field Name: PM10

Row Name:

Column Name:

Year: 2012

Field Note:

Death data are from the 2012 preliminary death file and subject to change. Population data for 2012 are from the Texas State Data Center from the Office of the State Demographer.

2. **Section Number:** Form11_Performance Measure #10

Field Name: PM10

Row Name:

Column Name:

Year: 2011

Field Note:

2011 data are based on a provisional death file for 2011. This file will be finalized in Aug 2013.

3. **Section Number:** Form11_Performance Measure #10

Field Name: PM10

Row Name:

Column Name:

Year: 2010

Field Note:

June 2012: Mortality data for 2010 are final.

Denominator data are projections by the Office of the State Demographer.

PERFORMANCE MEASURE # 11

The percent of mothers who breastfed their infants at 6 months of age.

	<u>Annual Objective and Performance Data</u>				
	2008	2009	2010	2011	2012
Annual Performance Objective	37	48.5	56	51	54
Annual Indicator	46.9	48.5	50.0	51.6	53.3
Numerator	189,896	194,919	192,873	194,540	207,727
Denominator	405,242	401,610	385,746	376,684	389,901
Data Source	National Immunization Survey	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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

	<u>Annual Objective and Performance Data</u>				
	2013	2014	2015	2016	2017
Annual Performance Objective	54	56	56	58	58
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. Section Number: Form11_Performance Measure #11

Field Name: PM11

Row Name:

Column Name:

Year: 2012

Field Note:

2010, 2011, and 2012 data are projections from the National Immunization Survey (NIS) based on 2004-2009 data. 2009 was the most up-to-date data available at time of reporting. From the NIS, the reported percentages for 2007 is 48.7%, 2008 is 42.2%, 2009 it is 50.7%.

2. Section Number: Form11_Performance Measure #11

Field Name: PM11

Row Name:

Column Name:

Year: 2011

Field Note:

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.

3. Section Number: Form11_Performance Measure #11

Field Name: PM11

Row Name:

Column Name:

Year: 2010

Field Note:

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.

PERFORMANCE MEASURE # 12

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	96	94	94	94	96.5
Annual Indicator	93.1	95.8	96.0	96.3	95.9
Numerator	383,596	391,126	376,976	369,769	373,745
Denominator	412,099	408,391	392,752	384,071	389,901
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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	96.5	96.5	96.5	96.5	96.5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2012

Field Note:

The denominator is from the 2012 preliminary birth file and subject to change. The numerator is final.

2. **Section Number:** Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence. The denominator is from the 2011 provisional birth file. These data will be finalized in Aug 2013.

3. **Section Number:** Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2010

Field Note:

Update: 2010 births are final.

Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence.

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	20	20	19.5	17	14
Annual Indicator	17.9	16.3	16.3	15.4	14.6
Numerator	1,216,968	1,133,117	1,152,738	1,059,874	1,007,822
Denominator	6,783,441	6,966,193	7,072,725	6,882,300	6,902,892
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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	14	13.7	13.7	13.7	13.7
Annual Indicator					
Numerator					
Denominator					

Field Level Notes**1. Section Number:** Form11_Performance Measure #13**Field Name:** PM13**Row Name:****Column Name:****Year:** 2012**Field Note:**

2011 data were taken from the 2012 Current Population Survey administered by the Census Bureau. The 2012 is a linear estimate using the 2008-2011 data.

2. Section Number: Form11_Performance Measure #13**Field Name:** PM13**Row Name:****Column Name:****Year:** 2011**Field Note:**

2011 data were taken from the 2012 Current Population Survey administered by the Census Bureau.

3. Section Number: Form11_Performance Measure #13**Field Name:** PM13**Row Name:****Column Name:****Year:** 2010**Field Note:**

Update: 2010 data is now based on the Census data.

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

PERFORMANCE MEASURE # 14

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	21	23	29	31	33
Annual Indicator	31.5	31.4	34.7	35.7	32.7
Numerator	146,631	140,676	171,101	177,273	177,996
Denominator	465,319	448,039	492,775	496,167	543,569

Data Source WIC Program Data 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	32	31	30	30	30
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2012

Field Note:

Data provided by the Texas WIC program

2. **Section Number:** Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2011

Field Note:

Data provided by Texas WIC program

3. **Section Number:** Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2010

Field Note:

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.

PERFORMANCE MEASURE # 16

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	6	5.5	5.2	7.5	7.4
Annual Indicator	7.2	8.7	7.5	8.0	8.5
Numerator	134	163	142	155	159
Denominator	1,866,100	1,882,929	1,883,124	1,927,596	1,869,019
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	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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	8	8	7.8	7.8	7.5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16

Field Name: PM16

Row Name:

Column Name:

Year: 2012

Field Note:

The 2012 death file is preliminary and subject to change. The denominator is from the Texas Data Center from the Office of the State Demographer.

2. **Section Number:** Form11_Performance Measure #16

Field Name: PM16

Row Name:

Column Name:

Year: 2011

Field Note:

The 2011 data are from the provisional 2011 death file. This file will be finalized in August 2013. The denominator is a population estimate by the Office of the State Demographer.

3. **Section Number:** Form11_Performance Measure #16

Field Name: PM16

Row Name:

Column Name:

Year: 2010

Field Note:

June 2012: Mortality data for 2010 are now final.

Denominator is 2010 Census data.

PERFORMANCE MEASURE # 17

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

	<u>Annual Objective and Performance Data</u>				
	2008	2009	2010	2011	2012
Annual Performance Objective	52	52	52	50	50
Annual Indicator	50.2	50.1	49.8	48.2	45.6
Numerator	2,946	2,967	2,810	2,631	2,595
Denominator	5,865	5,920	5,641	5,455	5,691
Data Source	Annual Hospital Survey and Natality Data	Annual Hospital Survey and Natality Data	Annual Hospital Survey and Natality Data	Annual Hospital Survey and Natality Data	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. <i>(Explain data in a year note. See Guidance, Appendix IX.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Data Provisional or Final?				Final	Provisional

	<u>Annual Objective and Performance Data</u>				
	2013	2014	2015	2016	2017
Annual Performance Objective	50	50	52	52	52
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #17
Field Name: PM17
Row Name:
Column Name:
Year: 2012
Field Note:
 The 2012 Survey of Hospitals was not complete by the time of the report. The list of High Risk Delivery Hospitals is based on the 2011 Survey of Hospitals. The 2012 birth file is preliminary and subject to change.
- Section Number:** Form11_Performance Measure #17
Field Name: PM17
Row Name:
Column Name:
Year: 2011
Field Note:
 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.
- Section Number:** Form11_Performance Measure #17
Field Name: PM17
Row Name:
Column Name:
Year: 2010
Field Note:
 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.

PERFORMANCE MEASURE # 18

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

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	73	74	66	58	64
Annual Indicator	57.9	54.9	56.9	59.4	62.1
Numerator	234,829	220,473	219,333	223,994	242,148
Denominator	405,242	401,599	385,746	377,124	389,901
Data Source	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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	65	65	65	65	65
Annual Indicator					
Numerator					
Denominator					

Field Level Notes**1. Section Number:** Form11_Performance Measure #18**Field Name:** PM18**Row Name:****Column Name:****Year:** 2012**Field Note:**

Data are from the 2012 preliminary birth file and subject to change.

2. Section Number: Form11_Performance Measure #18**Field Name:** PM18**Row Name:****Column Name:****Year:** 2011**Field Note:**

2011 data are based on a provisional birth file from the Center for Health Statistics.

3. Section Number: Form11_Performance Measure #18**Field Name:** PM18**Row Name:****Column Name:****Year:** 2010**Field Note:**

Update: 2010 data is final.

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(iii) AND 486 (a)(2)(A)(iii)]
STATE: TX

Form Level Notes for Form 11

None

STATE PERFORMANCE MEASURE # 1 - REPORTING YEAR

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

Annual Objective and Performance Data					
	2008	2009	2010	2011	2012
Annual Performance Objective	90	85	85	80	80
Annual Indicator	100.4	97.8	97.0	94.6	89.2
Numerator	1,624	1,582	1,568	1,530	1,442
Denominator	1,617	1,617	1,617	1,617	1,617
Data Source	Permanency Planning and Family Based Alt. Report				
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data					
	2013	2014	2015	2016	2017
Annual Performance Objective	80	80	80	80	80
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_State Performance Measure #1
Field Name: SM1
Row Name:
Column Name:
Year: 2012
Field Note:
 Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- July 2012 (covers March 1, 2012 to August 31, 2012)

The FY12 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 for Individuals with an Intellectual Disability or Related Conditions decreased slightly, there was an increase in the number of children in Home and Community-Based Service facilities.
- Section Number:** Form11_State Performance Measure #1
Field Name: SM1
Row Name:
Column Name:
Year: 2011
Field Note:
 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.
- Section Number:** Form11_State Performance Measure #1
Field Name: SM1
Row Name:
Column Name:
Year: 2010
Field Note:
 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.

STATE PERFORMANCE MEASURE # 2 - REPORTING YEAR

Rate of excess feto-infant mortality in Texas.

	<u>Annual Objective and Performance Data</u>				
	2008	2009	2010	2011	2012
Annual Performance Objective	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="1.5"/>	<input type="text" value="1.5"/>
Annual Indicator	<input type="text" value="1.6"/>	<input type="text" value="1.5"/>	<input type="text" value="1.8"/>	<input type="text" value="1.6"/>	<input type="text" value="1.7"/>
Numerator	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Denominator	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Data Source	Nativity and Mortality Data	Nativity and Mortality Data	Nativity and Mortality Data	Nativity and Mortality Data	Nativity and Mortality Data
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2013	2014	2015	2016	2017
Annual Performance Objective	<input type="text" value="1.4"/>	<input type="text" value="1.4"/>	<input type="text" value="1.3"/>	<input type="text" value="1.3"/>	<input type="text" value="1.3"/>
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. Section Number: Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2012

Field Note:

Fetal death information is not yet available for 2012. The rate for 2012 is estimated using the linear trend line estimated based on the 2008-2011 data.

2. Section Number: Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2011

Field Note:

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)

Nativity, Mortality, and Fetal death data for 2011 are estimated. Estimates are based on a linear trend of final data from 2006-2010.

3. Section Number: Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2010

Field Note:

Update: 2010 data are 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 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.

STATE PERFORMANCE MEASURE # 3 - REPORTING YEAR

The percent of active or maintained Title V funded initiatives that include a mental or behavioral health component.

	<u>Annual Objective and Performance Data</u>				
	2008	2009	2010	2011	2012
Annual Performance Objective	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Annual Indicator	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Numerator	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Denominator	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Data Source					
Is the Data Provisional or Final?					

	<u>Annual Objective and Performance Data</u>				
	2013	2014	2015	2016	2017
Annual Performance Objective	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #3

Field Name: SMB

Row Name:

Column Name:

Year: 2012

Field Note:

The MCH Initiatives Survey has been created and will be distributed in July 2013 to appropriate staff. Data for this measure will be available in August 2013.

2. **Section Number:** Form11_State Performance Measure #3

Field Name: SMB

Row Name:

Column Name:

Year: 2011

Field Note:

The MCH survey assessing program readiness and capacity to address mental and behavioral health has not been conducted.

3. **Section Number:** Form11_State Performance Measure #3

Field Name: SMB

Row Name:

Column Name:

Year: 2010

Field Note:

The MCH survey assessing program readiness and capacity to address mental and behavioral health has not been conducted.

STATE PERFORMANCE MEASURE # 4 - REPORTING YEAR

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

	<u>Annual Objective and Performance Data</u>				
	2008	2009	2010	2011	2012
Annual Performance Objective	16.5	16	15.5	14.5	12.5
Annual Indicator	15.7	15.0	12.5	16.0	14.2
Numerator	743,014	720,955	618,039	767,728	682,793
Denominator	4,732,576	4,806,369	4,937,333	4,792,602	4,808,400
Data Source	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey
Is the Data Provisional or Final?				Final	Provisional

	<u>Annual Objective and Performance Data</u>				
	2013	2014	2015	2016	2017
Annual Performance Objective	12.5	12	12	11.5	11.5
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_State Performance Measure #4
Field Name: SM4
Row Name:
Column Name:
Year: 2012
Field Note:
 The 2012 data was estimated by calculating the average percent change between 2007-2010, then estimating the 2012 percentage from the 2011 percentage using this average percent change. Denominator is the 2012 projected population from Texas State Data Center of the Office of the State Demographer.
- Section Number:** Form11_State Performance Measure #4
Field Name: SM4
Row Name:
Column Name:
Year: 2011
Field Note:
 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.

 2011 BRFSS data is current. In 2011 the CDC changed it's weighting procedure for the BRFSS, therefore all data from 2011 on will not be comparable to data collected before 2011.
- Section Number:** Form11_State Performance Measure #4
Field Name: SM4
Row Name:
Column Name:
Year: 2010
Field Note:
 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.

STATE PERFORMANCE MEASURE # 5 - REPORTING YEAR

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

	<u>Annual Objective and Performance Data</u>				
	2008	2009	2010	2011	2012
Annual Performance Objective				38	38
Annual Indicator	37.1	39.3	39.4	39.4	39.5
Numerator	1,432,960	1,529,673	1,508,282	1,525,595	1,644,050
Denominator	3,865,559	3,894,222	3,831,601	3,870,381	4,163,077
Data Source	School Physical Activity & Nutrition Survey	School Physical Activity & Nutrition Survey	School Physical Activity & Nutrition Survey	School Physical Activity & Nutrition Survey	Youth Risk Behavior Survey
Is the Data Provisional or Final?				Final	Provisional

	<u>Annual Objective and Performance Data</u>				
	2013	2014	2015	2016	2017
Annual Performance Objective	37	37	36	36	36
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_State Performance Measure #5
Field Name: SM5
Row Name:
Column Name:
Year: 2012
Field Note:
 The 2012 data were estimated by using the Texas population ages 8-18; multiplying the 4th grade obesity percent by children 8-11, the 8th grade obesity percent by ages 12-14, and the 11th grade obesity percent by ages 15-18.
- Section Number:** Form11_State Performance Measure #5
Field Name: SM5
Row Name:
Column Name:
Year: 2011
Field Note:
 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.
- Section Number:** Form11_State Performance Measure #5
Field Name: SM5
Row Name:
Column Name:
Year: 2010
Field Note:
 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.

STATE PERFORMANCE MEASURE # 6 - REPORTING YEAR

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

	<u>Annual Objective and Performance Data</u>				
	2008	2009	2010	2011	2012
Annual Performance Objective				14	11.5
Annual Indicator	14.1	14.5	11.5	11.5	10.9
Numerator	917	954	831	829	752
Denominator	6,495,224	6,557,436	7,245,842	7,179,876	6,902,892
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	Mortality Data and Office of the State Demographer
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2013	2014	2015	2016	2017
Annual Performance Objective	11	11	11	10.5	10.5
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_State Performance Measure #6
Field Name: SM6
Row Name:
Column Name:
Year: 2012
Field Note:
 Death file data for 2012 is preliminary and subject to change. When the 2012 file is finalized, we expect this number to increase. The 2012 death file contains more "pending" manners of death than in previous years.
- Section Number:** Form11_State Performance Measure #6
Field Name: SM6
Row Name:
Column Name:
Year: 2011
Field Note:
 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.
- Section Number:** Form11_State Performance Measure #6
Field Name: SM6
Row Name:
Column Name:
Year: 2010
Field Note:
 Update: 2010 death data is final.

 Denominator is provided by the Office of the State Demographer. Data is based on the 2010 Census data.

STATE PERFORMANCE MEASURE # 7 - REPORTING YEAR

The percent of Title V funded initiatives that utilize or promote the use of evidence based practices.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	<input type="text"/>				
Annual Indicator	<input type="text"/>				
Numerator	<input type="text"/>				
Denominator	<input type="text"/>				
Data Source					
Is the Data Provisional or Final?					

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #7

Field Name: SM7

Row Name:

Column Name:

Year: 2012

Field Note:

The MCH Initiatives Survey has been developed and will be distributed to appropriate staff in July 2013. Data for this measure will be available in August 2013.

2. **Section Number:** Form11_State Performance Measure #7

Field Name: SM7

Row Name:

Column Name:

Year: 2011

Field Note:

The MCH survey assessing program readiness and capacity to address mental and behavioral health has not been conducted.

3. **Section Number:** Form11_State Performance Measure #7

Field Name: SM7

Row Name:

Column Name:

Year: 2010

Field Note:

The MCH survey assessing program utilization of research findings and/or evidence-based practices for program improvement and development has not been conducted.

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (a)(2)(B)(iii) AND 506 (a)(2)(A)(iii)]
STATE: TX

Form Level Notes for Form 12

None

OUTCOME MEASURE # 01

The infant mortality rate per 1,000 live births.

	Annual Objective and Performance Data				
	2008	2009	2010	2011	2012
Annual Performance Objective	5.5	6.5	5.5	6	6
Annual Indicator	6.2	6.0	6.1	5.7	5.5
Numerator	2,530	2,394	2,362	2,200	2,157
Denominator	405,242	401,599	385,746	384,998	389,901
Data Source	Nativity and Mortality Data	Nativity and Mortality Data	Nativity and Mortality Data	Nativity and Mortality Data	Nativity and Mortality 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

	Annual Objective and Performance Data				
	2013	2014	2015	2016	2017
Annual Performance Objective	5.5	5.5	5.4	5.4	5.3
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 1

Field Name: OMD1

Row Name:

Column Name:

Year: 2012

Field Note:

2012 birth and death data are preliminary and subject to change.

2. **Section Number:** Form12_Outcome Measure 1

Field Name: OMD1

Row Name:

Column Name:

Year: 2011

Field Note:

2011 birth and death data are provisional. These data will be finalized in Aug 2013

3. **Section Number:** Form12_Outcome Measure 1

Field Name: OMD1

Row Name:

Column Name:

Year: 2010

Field Note:

June 2012: birth and death data are now final.

OUTCOME MEASURE # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	1.7	2.5	2.3	2.2	2.2
Annual Indicator	1.7	2.3	2.1	2.2	1.9
Numerator	10.1	12.5	11.3	11.2	10.3
Denominator	6	5.5	5.5	5	5.3

Data Source	2008	2009	2010	2011	2012
	Natality and Mortality 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	1.9	1.9	1.8	1.8	1.7

Annual Indicator

Numerator

Denominator

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. Section Number: Form12_Outcome Measure 2

Field Name: OM02

Row Name:

Column Name:

Year: 2012

Field Note:

2012 data are preliminary and subject to change.

2. Section Number: Form12_Outcome Measure 2

Field Name: OM02

Row Name:

Column Name:

Year: 2011

Field Note:

Data for 2011 are provisional and will be finalized Aug 2013

3. Section Number: Form12_Outcome Measure 2

Field Name: OM02

Row Name:

Column Name:

Year: 2010

Field Note:

Update July 2012: 2010 data are now final.

OUTCOME MEASURE # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	3.5	3.5	3.5	3.8	3.8
Annual Indicator	3.9	3.8	3.9	3.8	3.4
Numerator	1,576	1,514	1,507	1,445	1,345
Denominator	405,242	401,599	385,746	384,998	389,901

Data Source	2008	2009	2010	2011	2012
	Natality and Mortality Data	Mortality 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	3.4	3.4	3.4	3.3	3.3

Annual Indicator

Numerator

Denominator

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

1. Section Number: Form12_Outcome Measure 3

Field Name: OM03

Row Name:

Column Name:

Year: 2012

Field Note:

2012 data are preliminary and subject to change.

2. Section Number: Form12_Outcome Measure 3

Field Name: OM03

Row Name:

Column Name:

Year: 2011

Field Note:

Death and birth data for 2011 are provisional. These data will be finalized in Aug 2013.

3. Section Number: Form12_Outcome Measure 3

Field Name: OM03

Row Name:

Column Name:

Year: 2010

Field Note:

Update: 2010 data is final.

OUTCOME MEASURE # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	2	1.9	1.9	2.1	2.1
Annual Indicator	2.4	2.2	2.4	2.0	2.1
Numerator	954	880	934	755	812
Denominator	405,242	401,599	385,746	384,998	389,901
Data Source	Nativity and Mortality 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	2	2	1.9	1.9	1.9
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

Field Level Notes

1. Section Number: Form12_Outcome Measure 4

Field Name: OMD4

Row Name:

Column Name:

Year: 2012

Field Note:

2012 birth and death data are preliminary and subject to change.

2. Section Number: Form12_Outcome Measure 4

Field Name: OMD4

Row Name:

Column Name:

Year: 2011

Field Note:

2011 birth and death data are provisional. These data will be finalized in Aug 2013.

3. Section Number: Form12_Outcome Measure 4

Field Name: OMD4

Row Name:

Column Name:

Year: 2010

Field Note:

Update: Natality and Mortality data for 2010 are final.

OUTCOME MEASURE # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	8.9	5.1	5	5.2	5
Annual Indicator	5.6	5.0	5.1	5.3	5.0
Numerator	2,286	2,013	1,969	2,031	1,958
Denominator	406,291	402,425	387,890	385,886	390,789
Data Source	Nativity, Mortality, and Fetal Death 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	5	4.9	4.9	4.9	4.9
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes**1. Section Number:** Form12_Outcome Measure 5**Field Name:** OM05**Row Name:****Column Name:****Year:** 2012**Field Note:**

2012 birth and death files are preliminary and subject to change. The 2012 fetal death file was not available at the time of the report. For fetal deaths >=28 weeks gestation, the 2011 number was used for the 2012 calculations.

2. Section Number: Form12_Outcome Measure 5**Field Name:** OM05**Row Name:****Column Name:****Year:** 2011**Field Note:**

2011 fetal, birth and death data are provisional. These data will be finalized in Aug 2013.

3. Section Number: Form12_Outcome Measure 5**Field Name:** OM05**Row Name:****Column Name:****Year:** 2010**Field Note:**

Update: 2010 data is final.

OUTCOME MEASURE # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	2008	2009	2010	2011	2012
Annual Performance Objective	21	19.5	19	19	19
Annual Indicator	20.7	21.0	17.2	18.9	17.9
Numerator	1,033	1,058	920	985	966
Denominator	4,987,021	5,049,935	5,358,744	5,198,817	5,390,676
Data Source	Nativity Data and Office of the State Demographer	Nativity Data and Office of the State Demographer	Nativity Data and Office of the State Demographer	Nativity Data and Office of the State Demographer	Nativity 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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Annual Objective and Performance Data

	2013	2014	2015	2016	2017
Annual Performance Objective	17.9	17.9	17.5	17.5	17.5
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes**1. Section Number:** Form12_Outcome Measure 6**Field Name:** OMD6**Row Name:****Column Name:****Year:** 2012**Field Note:**

2012 death data are preliminary and subject to change. Population data estimates are from the State Data Center from the Office of the State Demographer.

2. Section Number: Form12_Outcome Measure 6**Field Name:** OMD6**Row Name:****Column Name:****Year:** 2011**Field Note:**

2011 data are provisional and will be finalized in Aug 2013.

3. Section Number: Form12_Outcome Measure 6**Field Name:** OMD6**Row Name:****Column Name:****Year:** 2010**Field Note:**

June 2012: Death data for 2010 are final.

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (a)(2)(B)(iii) AND 506 (a)(2)(A)(iii)]
STATE: TX

Form Level Notes for Form 12

None

STATE OUTCOME MEASURE # 1 - REPORTING YEAR

The ratio of the Black perinatal mortality rate to the White perinatal mortality rate.

	<u>Annual Objective and Performance Data</u>				
	2008	2009	2010	2011	2012
Annual Performance Objective	1	3	3	2	2
Annual Indicator	2.0	2.3	1.8	2.0	1.8
Numerator	10	9	11	9	8.1
Denominator	5	4	6	4.5	4.5
Data Source	Nativity, Mortality, and Fetal Death Data	Nativity, Mortality, and Fetal Death Data	Nativity, Mortality, and Fetal Death Data	Nativity, Mortality, and Fetal Death Data	Nativity, Mortality, and Fetal Death Data
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2013	2014	2015	2016	2017
Annual Performance Objective	1.8	1.8	1.7	1.7	1.7
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

Field Level Notes

- Section Number:** Form12_State Outcome Measure 1
Field Name: SO1
Row Name:
Column Name:
Year: 2012
Field Note:
 The death and birth data from 2012 are preliminary and subject to change. The 2012 fetal death file was not available at the time of reporting, therefore, the number of fetal deaths >=28 weeks gestation was taken for each race from the 2011 fetal death file and combined with the 2012 death and birth data.
- Section Number:** Form12_State Outcome Measure 1
Field Name: SO1
Row Name:
Column Name:
Year: 2011
Field Note:
 Data from 2011 are provisional and will be finalized Aug 2013.
- Section Number:** Form12_State Outcome Measure 1
Field Name: SO1
Row Name:
Column Name:
Year: 2010
Field Note:
 Update June 2012: Data for 2010 have been finalized.

FORM 13
CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS
STATE: TX

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

4. Family members are involved in service training of CSHCN staff and providers.

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

6. Family members of diverse cultures are involved in all of the above activities.

Total Score:

Rating Key

0 = Not Met

1 = Partially Met

2 = Mostly Met

3 = Completely Met

FORM NOTES FOR FORM 13

None

FIELD LEVEL NOTES

1. **Section Number:** Form13_Main
Field Name: Question1
Row Name: #1. Family members participate on advisory committee or task forces...
Column Name:
Year: 2014
Field Note:
Texas Parent to Parent has training available to a broad array of providers through the Family-to-Family Health Information Center grant.
2. **Section Number:** Form13_Main
Field Name: Question2
Row Name: #2. Financial support (...) is offered for parent activities or parent groups.
Column Name:
Year: 2014
Field Note:
CSHCN SP supports the parent case management model through funding for community-based organizations providing this model of service delivery in three different areas across the state.
3. **Section Number:** Form13_Main
Field Name: Question3
Row Name: #3. Family members are involved in the Children with Special Health Care Needs...
Column Name:
Year: 2014
Field Note:
CSHCN SP staff include family members that share their expertise as family members of individuals with special health care needs and/or disabilities.
4. **Section Number:** Form13_Main
Field Name: Question5
Row Name: #5. Family members hired as paid staff or consultants to the State CSHCN program...
Column Name:
Year: 2014
Field Note:
The Texas Family Delegate is not a paid staff position or paid consultant position at DSHS; however, the Delegate is the parent of a child with special health care needs. Additionally, CSHCN SP staff include members that share their expertise as family members of individuals with special health care needs and/or disabilities.

FORM 14
LIST OF MCH PRIORITY NEEDS

[Sec. 505(a)(5)]

STATE: TX FY: 2014

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase, list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. Support and develop health care infrastructure that provides coordinated access to services in a culturally competent manner, addressing health issues across the life course.
2. Increase the availability of quality mental health and substance abuse services.
3. Increase the number of youth with special health care needs who receive necessary services to transition to all aspects of adult life.
4. Increase access to dental care.
5. Support community-based programs that strengthen parenting skills and promote healthy child and adolescent development.
6. Support the development of community-based systems that provide essential enabling services needed to improve health status.
7. Improve the organization of community-based systems of care for children and youth with special health care needs.
8. Use population-based services including health promotion and disease prevention interventions to improve health outcomes of the MCH population.
9. 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.
10. Promote the expansion of new or existing evidence-based interventions to address maternal and child health needs.

FORM NOTES FOR FORM 14

None

FIELD LEVEL NOTES

None

FORM 15
TECHNICAL ASSISTANCE(TA) REQUEST

STATE: TX

APPLICATION YEAR: 2014

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested <i>(max 250 characters)</i>	Reason(s) Why Assistance Is Needed <i>(max 250 characters)</i>	What State, Organization or Individual Would You suggest Provide the TA (if known) <i>(max 250 characters)</i>
1.	General Systems Capacity Issues If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text" value="NA"/>	Continued suggestions regarding ongoing efforts to integrate physical, mental, and behavioral health systems for MCH populations.	This topic remains a priority for DSHS. It was identified as a priority need and a state performance measure was developed as a result.	SAMHSA/HRSA
2.	General Systems Capacity Issues If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text" value="NA"/>	Continued development of community health worker / paraprofessional programs to address MCH needs.	Examples of existing models and programs, along with available training programs and other workforce development tools to help DSHS expand the existing state program.	HRSA/CDC
3.	General Systems Capacity Issues If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text" value="NA"/>	Understanding the role of social determinants of health and the life course perspective in serving the MCH population, including coordinating initiatives to improve birth outcomes.	These topics are an integral component of addressing DSHS' focus on reducing infant mortality.	HRSA
4.	Data-related Issues - Needs Assessment If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text" value="NA"/>	Suggestions for staff development to maximize the available data from the Data Resource Center in preparation of the upcoming five-year needs assessment.	Staff have various backgrounds and experiences along with statisticians and epidemiologists; additional background info and education will help staff to be on the same platform for use and interpreting data.	Data Resource Center
5.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/>			
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/>			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/>			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/>			
9.				

	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/>			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/>			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/>			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: <input type="text"/>			

FORM NOTES FOR FORM 15

None

FIELD LEVEL NOTES

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: TX

SP() #

PERFORMANCE MEASURE: Change in percentage of CYSHCN living in congregate care settings as percent of base year 2003.

STATUS: Active

GOAL All CYSHCN live in families, in communities, consistent with permanency planning principles.

DEFINITION Change in percentage of CYSHCN living in congregate care settings as percent of base year 2003.

Numerator:

Number of CYSHCN living in congregate care settings at the end of the current year.

Denominator:

Number of CYSHCN living in congregate care in base year (2003).

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

Objective 6-7

Reduce the number of people with disabilities in congregate care facilities, consistent with permanency planning principles. Target 6-7b: Zero persons aged 21 years and under in congregate care facilities.

DATA SOURCES AND DATA ISSUES

Data Source(s): State Health and Human Services Commission - Office of Program Coordination for Children and Youth. Data Issue(s): Starting in FY04, as indicated above and on Form 11, the denominator for this performance measure was changed to reflect data from a base year of 2003 (instead of the data from the previous year). Also, to improve data accuracy, the count of children in congregate care settings for the base year and future years was expanded to include children in Home and Community Services group homes and Department of Family and Protective Services institutions in addition to those in state schools, Intermediate Care Facilities (MR), and in nursing homes.

SIGNIFICANCE

Many children with activity limitations, cognitive impairments, or behavioral conditions, need ongoing and long-term assistance that may be (or may have been) available only in congregate care settings. On 8/31/2009, there were 1,582 children who were institutionalized in state schools, Intermediate Care Facilities (MR), Home and Community Services group homes, Department of Family and Protective Services institutions, and nursing homes. Every CYSHCN belongs in a family with a consistent caregiver who takes responsibility for the child's growth, development, and overall well-being. CYSHCN still reside in nursing homes and other congregate care settings. Families with CYSHCN need family support services and care options so that CYSHCN can remain in families within the community.

SP() #

PERFORMANCE MEASURE:

Rate of excess fetoinfant mortality in Texas.

STATUS:

Active

GOAL

To improve perinatal health and reduce modifiable infant morbidity and mortality in Texas.

DEFINITION

Calculate differences in excess fetoinfant mortality between reference and non-reference groups through Perinatal Periods of Risk (PPOR) analysis. Deaths with a birthweight of 500+ grams in the following age categories will be included in the analysis: fetal deaths (fetal death of 24 completed weeks gestation or more); neonatal deaths (<28 days); and postneonatal deaths (>28 days through 365 days). The reference group is a sub-population that represents at least 15% of the population and that has better outcomes across all 4 perinatal periods of risk. This is typically non-Hispanic white women, aged 20+ with 13+ years of education. Classification into categories of the PPOR map are as follows: Maternal Health/Prematurity: Birthweight 500-1499 grams with fetal death, neonatal death and postneonatal death; Maternal Care: 1500+ grams with fetal death; Newborn Care: 1500+ grams with neonatal death; Infant Health: 1500+ grams with postneonatal death.

Numerator:

Number of fetal deaths (24+ weeks and 500+ grams) + number of infant deaths (500+ grams).

Denominator:

Number of fetal deaths (24+ weeks and 500+ grams) + number of live births (500+ grams).

Units: Yes **Text:** Text

HEALTHY PEOPLE 2020 OBJECTIVE

Objective 16-1

Reduce fetal/infant deaths.

Objective 16-10

Reduce low birth weight (LBW) and very low birth weight (VLBW).

DATA SOURCES AND DATA ISSUES

Data Source(s): Birth records matched to infant death records and fetal death records (natality, mortality, and fetal mortality records). Data Issue(s): Delay in availability of data. Data for multiple years must be aggregated for best reliability.

SIGNIFICANCE

Infant mortality is an important indicator of a population's health, indicating both current population health status and predicting the health of the newest generation (NCHS, 2001). Inclusion of fetal mortality allows analysis of perinatal mortality, which is an important indicator for quality of perinatal health care. The PPOR analysis allows for identification of potential gaps and targeted activities to improve perinatal health and reduce infant mortality. The PPOR approach uses birthweight and age of death to classify fetoinfant mortality into four strategic prevention areas: maternal health/prematurity, maternal care, newborn care, and infant health. The PPOR approach assumes that not all deaths are preventable, and focuses on "excess deaths", or deaths that are in excess of a reference group with the best outcomes in each of the four categories. PPOR mapping of fetoinfant mortality enables identification of areas in which there are the greatest opportunities for impact. Each of these categories provides guidance for possible points of intervention. Deeper analyses and planning efforts further enable prioritization of efforts and resources for those areas where the greatest changes can be made. In addition, the PPOR map facilitates tracking of changes in each of the four categories independent of each other.

SP() #

PERFORMANCE MEASURE:

The percent of active or maintained Title V funded initiatives that include a mental or behavioral health component.

STATUS:

Active

GOAL

To increase the integration of mental and behavioral health into initiatives for MCH and CYSHCN populations.

DEFINITION

Ascale applied to organizational readiness will be used to assess the stage of the initiative (Pre-contemplation, Contemplation, Preparation, Action and Maintenance). Only those initiatives in the Action and Maintenance stage will be included in the measure. For an initiative to qualifying as having a behavioral or mental health component it must have or do at least one of the following: (1) focus on a behavioral change in the target population, (2) incorporate mental health or substance abuse treatment into the initiative, (3) promote physical activity and positive behavioral change, (4) promote awareness of mental health issues, (5) work to reduce child abuse and neglect, (6) build inter-program collaboration or data availability between programs focused on MCH or CYSHCN and those focused on mental and behavioral health or (7) build relations with mental health organizations through formal a MOU or through Title V staff participating on an advisory board.

Numerator:

The number of active and maintenance stage Title V initiatives that include a mental or behavioral health component.

Denominator:

The total number of active and maintenance stage Title V initiatives.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

Objective 18-6 (Developmental)

Increase the number of persons seen in primary health care who receive mental health screening and assessment.

Objective 26-23 (Developmental)

Increase the number of communities using partnerships or coalition models to conduct comprehensive substance abuse prevention efforts.

DATA SOURCES AND DATA ISSUES

Program assessment developed by DSHS Office of Program Decision Support.

SIGNIFICANCE

There are a variety of opportunities to incorporate mental and behavioral health into efforts that currently exist. Through working to increase capacity of current partners related to mental health and wellness, it is possible to increase the infrastructure and capacity to find and serve those who need services. For example, if we work with partners to improve domestic violence screening and data collection, they will find and refer more victims to needed services and provide data about the health impacts of this issue.

SP() #

PERFORMANCE MEASURE:

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

STATUS:

Active

GOAL

Decrease the percent of current cigarette smoking among women 18 to 44.

DEFINITION

Percentage of women ages 18 to 44 who are current cigarette smokers.

Numerator:

Number of women between the ages of 18 to 44 who report smoking everyday or somedays.

Denominator:

Number of women between the ages of 18 to 44.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

Objective 16-17

Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.

Objective 27-6

Increase smoking cessation during pregnancy.

DATA SOURCES AND DATA ISSUES

Data Source(s): Behavior Risk Factor Surveillance Survey (BRFSS). Data Issue(s): None.

SIGNIFICANCE

Data link fetal exposure to tobacco to prematurity, low birth weight, Sudden Infant Death Syndrome, and asthma and other respiratory problems, all of which can increase perinatal, infant, neonatal, postneonatal, and child mortality. Reducing the rate of women of childbearing age that smoke in Texas will have a positive impact on perinatal and child health outcomes.

SP() #

PERFORMANCE MEASURE:

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

STATUS:

Active

GOAL

Decrease the percent of school-aged children in grades 3-12 who are identified as overweight or obese.

DEFINITION

Percent of school-aged children who are at or above 85th percentile for body mass index (BMI).

Numerator:

Number of school-aged children who are at or above 85th percentile for BMI.

Denominator:

Number of school-aged children in Texas.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

Objective 19-3

Reduce the proportion of children and adolescents who are overweight or obese.

Objective 19-15 (Developmental)

Increase the proportion of children and adolescents aged 6 to 19 years whose intake of meals and snacks at school contributes to good overall dietary quality.

DATA SOURCES AND DATA ISSUES

Data Source(s): Texas Education Agency FITNESSGRAM- grades 3-12; School Physical Activity and Nutrition (SPAN)-4th, 8th, and 11th grades, and matched 4th grade parent; Texas Youth Risk Behavior Surveillance System (YRBSS)-grades 9-12. Data Issue(s): SPAN may not be updated in the next 5 years.

SIGNIFICANCE

Obesity is the most common disorder for children in the developed world, and the prevalence continues to increase. There are substantial risks for morbidity in obese children even before they reach adulthood. Obesity during adolescence affects blood pressure and blood lipid, lipoprotein, and insulin levels. Perhaps the most widespread consequences of childhood and adolescent obesity are psychosocial, including discrimination. If obesity in childhood persists into the adult years, the morbidity and mortality is greater than if the obesity developed as an adult. Longitudinal studies of children followed into young adulthood suggest that overweight children may become overweight adults, particularly if obesity is present during adolescence.

SP() #

PERFORMANCE MEASURE:

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

STATUS:

Active

GOAL

To improve the health and safety of children by minimizing preventable deaths.

DEFINITION

Incidence rates of preventable (accident, suicide, homicide) child deaths (0-17 year olds) in Texas.

Numerator:

Number of preventable (accident, suicide, homicide) deaths to children 0-17 years old in Texas.

Denominator:

Number of children 0-17 years old in Texas.

Units: 100000 **Text:** Rate

HEALTHY PEOPLE 2020 OBJECTIVE

Objective 15-15

Reduce deaths caused by motor vehicle crashes.

Objective 15-29

Reduce drownings.

DATA SOURCES AND DATA ISSUES

Data Source(s): Texas Vital Records and Texas State Data Center and Office of the State Demographer. Data Issue(s): Delay in availability of the data.

SIGNIFICANCE

Death of a child is a sentinel event in a community, and the impact of each death is far-reaching, especially if the death was preventable. Understanding why children die and how future deaths can be prevented is the goal of Child Fatality Review. Further developing the infrastructure to collect and analyze this information will provide information that can drive community-based and State efforts to protect Texas children from preventable deaths.

SP() #

PERFORMANCE MEASURE:

The percent of Title V funded initiatives that utilize or promote the use of evidence based practices.

STATUS:

Active

GOAL

Increase the number of initiatives that are based upon or promote the use of evidence based practices.

DEFINITION

Qualifying initiatives are those whose goal it is to directly affect a target MCH or CYSHCN population either through direct care or a population based initiative. Further, to qualify these initiatives should be in the active or maintenance stage of organizational readiness.

Numerator:

Qualifying initiatives that include or promote practices that are listed with a recognized authority on the subject, such as but not limited to the National Registry of Evidence-based Program and Practices, the Office of Adolescent Health, or the Association of Maternal and Child Health Programs.

Denominator:

All qualifying initiatives.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Data Source(s): Program assessment developed by DSHS Office of Program Decision Support. Data Issue(s): Mechanism for collecting consistent information and demonstrating programmatic changes.

SIGNIFICANCE

The health-related needs for the MCH populations are better addressed through effective use of research findings and integrated system approaches. This will result in targeted interventions that will achieve improved health outcomes more cost efficiently and encourage decision makers to make data/evidence-driven decisions about programs and policies from a population perspective.

SQ() #

OUTCOME MEASURE:

The ratio of the Black perinatal mortality rate to the White perinatal mortality rate.

STATUS:

Active

GOAL

To reduce the disparity (ratio) between the Black and White perinatal mortality.

DEFINITION

The ratio of the Black perinatal mortality rate to the White perinatal mortality rate.

Numerator:

The Black perinatal mortality rate per 1,000 live births.

Denominator:

The White perinatal mortality rate per 1,000 live births.

Units: 1 **Text:** Ratio

HEALTHY PEOPLE 2020 OBJECTIVE

DATA SOURCES AND DATA ISSUES

Vital records collected by the State.

SIGNIFICANCE

Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care. Overall, there were 2,286 or 5.6 per 1,000 live births and fetal deaths in 2008. These deaths revealed a significant racial disparity. The disparity rate for Black perinatal mortality rate (9.6 per 1,000 live births) is more than twice the White rate of 4.5 per 1,000 live births. Black women are twice as likely as White women to experience low birth weight, neonatal, and fetal deaths.

FORM NOTES FOR FORM 16

None

FIELD LEVEL NOTES

1. Section Number: Form16_State Performance Measure 3

Field Name: SPM3

Row Name:

Column Name:

Year: 2014

Field Note:

07/01/2013 - State Performance Measure 3 has changed starting FY14. Below is the measure language for FY11, 12, and 13.

Performance Measure: The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.

Status: Active

Goal: To increase capacity to address mental and behavioral health for MCH populations.

Definition: Current capacity will be measured as a benchmark through an MCH survey. Based upon the survey, a plan will be developed to increase the capacity to address mental health and behavioral health for MCH populations. A scale based on the stages of change as applied to organizational readiness will be used to assess program readiness and capacity to address mental and behavioral health: 1= Pre-contemplation; 2=Contemplation; 3=Preparation; 4= Action; and 5=Maintenance. The scale is based on responses to survey questions that address staff readiness and awareness, evaluation and data, fiscal support, leadership support, community partnership support and overall capacity to address mental and behavioral health for MCH populations.

Numerator: Number of programs that are working to enhance statewide capacity to address mental and behavioral health for MCH populations as evidenced by a program scoring in the action (4) or maintenance (5) categories on the stages of change scale demonstrating program capacity.

Denominator: Number of DSHS program serving MCH populations in Texas.

Units: 100

Type: Percent

Healthy People 2020 Objective:

Objective 18-6 (Developmental)

Increase the number of persons seen in primary health care who receive mental health screening and assessment.

Objective 26-23 (Developmental)

Increase the number of communities using partnerships or coalition models to conduct comprehensive substance abuse prevention efforts.

Data Sources and Data Issues: Program assessment developed by DSHS Office of Program Decision Support.

Significance: There are a variety of opportunities to incorporate mental and behavioral health into efforts that currently exist. Through working to increase capacity of current partners related to mental health and wellness, it is possible to increase the infrastructure and capacity to find and serve those who need services. For example, if we work with partners to improve domestic violence screening and data collection, they will find and refer more victims to needed services and provide data about the health impacts of this issue.

2. Section Number: Form16_State Performance Measure 7

Field Name: SPM7

Row Name:

Column Name:

Year: 2014

Field Note:

07/01/2013 - State Performance Measure 7 changed starting FY14. Below is the measure language for FY11, 12, and 13.

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

Status: Active

Goal: Increase the number of DSHS programs using research findings and/or evidence-based practices to target populations.

Definition: Percent of DSHS programs that utilize research findings (evidence that support implementation of best practices) and evidence-based practices (EBPs) (evidence from rigorous evaluation/research designs that have direct impact on health outcomes) to make programmatic decisions. A scale based on the stages of change as applied to organizational readiness will be used to assess program utilization of EBPs: 1= Pre-contemplation stage; 2=Contemplation; 3=Preparation; 4= Action; and 5=maintenance. The scale is based on responses to survey questions that address staff readiness and awareness, evaluation and data, fiscal support, leadership support, community partnership support and overall capacity to implement EBPs.

Numerator: Number of DSHS programs serving MCH populations that utilize research findings and evidence-based practices to make programmatic decisions in Texas as evidenced by a program scoring in the action (4) or maintenance (5) categories on the stages of change scale demonstrating adoption of the practice of using evidence-based practice and research findings.

Denominator: Number of DSHS programs serving MCH populations in Texas.

Units: 100

Type: Percent

Healthy People 2020 Objective: n/a

Data Sources and Data Issues:

Data Source(s):

Program assessment developed by DSHS Office of Program Decision Support.

Data Issue(s):

Mechanism for collecting consistent information and demonstrating programmatic changes.

Significance: The health-related needs for the MCH populations are better addressed through effective use of research findings and integrated system approaches. This will result in targeted interventions that will achieve improved health outcomes more cost efficiently and encourage decision makers to make data/evidence-driven decisions about programs and policies from a population perspective.

FORM 17
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07 & 08 - MULTI-YEAR DATA
STATE: TX

Form Level Notes for Form 17

None

HEALTH SYSTEMS CAPACITY #01

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

	<u>Annual Indicator Data</u>				
	2008	2009	2010	2011	2012
Annual Indicator	24.1	25.6	20.3	18.9	17.6
Numerator	4,642	4,986	3,921	3,663	3,422
Denominator	1,927,981	1,951,170	1,928,473	1,938,308	1,945,480
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.					
<i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. Section Number: Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2012

Field Note:

The indicator is calculated using a linear trend from 2006 to 2011.

Denominator data are provided by the Office of the State Demographer.

2. Section Number: Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2011

Field Note:

The data are based on hospitalizations. Therefore, one person may account for multiple hospitalizations. The reported data may underestimate the true rate of hospitalizations for asthma because some Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the Texas Health Care Information Collection (THCIC).

Denominator data are provided by the Office of the State Demographer.

3. Section Number: Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2010

Field Note:

Data Source: Texas Hospital Inpatient Discharge 2010 Public Use Data File.

This indicator has been adjusted for final data.

The data are based on hospitalizations. Therefore, one person may account for multiple hospitalizations. The reported data may underestimate the true rate of hospitalizations for asthma because some Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the THCIC. Denominator data are provided by the Office of the State Demographer.

HEALTH SYSTEMS CAPACITY #02

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

	<u>Annual Indicator Data</u>				
	2008	2009	2010	2011	2012
Annual Indicator	81.8	81.3	92.9	94.0	94.6
Numerator	197,019	194,131	158,750	175,765	171,327
Denominator	240,911	238,927	170,927	186,955	181,023

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.

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(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #02

Field Name: HSC02

Row Name:

Column Name:

Year: 2012

Field Note:

Time period covered for this measure is Federal Fiscal Year 2012. Age group is based on age at the end of the federal fiscal year. Numerator is the number of eligibles under one year of age receiving at least one initial or periodic screening. Denominator is the number of individuals under one year of age eligible for EPSDT for 90 continuous days.

Source: Form CMS-416 Annual EPSDT Participation Report, FFY 2012.

2. **Section Number:** Form17_Health Systems Capacity Indicator #02

Field Name: HSC02

Row Name:

Column Name:

Year: 2011

Field Note:

Data Source: CMS-416 FFY2011

Numerator: Total eligibles receiving at least one initial or periodic screen

Denominator: Total individuals eligible for EPSDT for 90 continuous days

3. **Section Number:** Form17_Health Systems Capacity Indicator #02

Field Name: HSC02

Row Name:

Column Name:

Year: 2010

Field Note:

CMS-416 FFY2010

Reporting methods for the CMS-416 form were changed in FY2010. Prior to 2010, the total number of individuals eligible for any length of time served as the base population for the indicators reported. In 2010, the total number of individuals eligible for 90 continuous days served as the base population and is now reported as the denominator. The numerator is a subset of this population.

HEALTH SYSTEMS CAPACITY #03

The percent State Childrens Health Insurance Program (CHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

	<u>Annual Indicator Data</u>				
	2008	2009	2010	2011	2012
Annual Indicator	70.6	71.7	75.7	56.8	48.5
Numerator	45,208	64,065	68,729	15,623	1,846
Denominator	64,026	89,369	90,795	27,510	3,804
<p>Check this box if you cannot report the numerator because</p> <p>1. There are fewer than 5 events over the last year, and</p> <p>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.</p> <p style="text-align: center;"><i>(Explain data in a year note. See Guidance, Appendix IX.)</i></p>					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. Section Number: Form17_Health Systems Capacity Indicator #03

Field Name: HSC03

Row Name:

Column Name:

Year: 2012

Field Note:

Includes Traditional CHIP and Chip Perinate clients. The decrease in perinate enrollment is due to policy changes beginning 9/1/2010. Beginning 9/1/2010 CHIP Perinate newborns at or below 185% FPL were moved to Medicaid once they were born. Claims for screens will be under Medicaid, not CHIP. Periodic screen is defined as having a CPTcode = 99381 or 99391.

Data from 2008-2011 may include some children who were one year of age.

2. Section Number: Form17_Health Systems Capacity Indicator #03

Field Name: HSC03

Row Name:

Column Name:

Year: 2011

Field Note:

Source: Texas Health and Human Services Commission (HHSC). Program Contact: Gail Shevick (Gail.Shevick@hhsc.state.tx.us)

Please note the large decrease in Perinate enrollment and screens. This is due to a policy change that took effect Sept 1, 2010. Perinate newborns at or below 185% FPL are now moved to Medicaid. Their screens will be billed under their Medicaid ID, and not in CHIP.

3. Section Number: Form17_Health Systems Capacity Indicator #03

Field Name: HSC03

Row Name:

Column Name:

Year: 2010

Field Note:

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

HEALTH SYSTEMS CAPACITY #04

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

	<u>Annual Indicator Data</u>				
	2008	2009	2010	2011	2012
Annual Indicator	59.4	60.2	63.1	65.3	65.8
Numerator	240,687	241,804	243,537	246,130	250,471
Denominator	405,242	401,599	385,746	377,124	380,495
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

- Section Number:** Form17_Health Systems Capacity Indicator #04
Field Name: HSC04
Row Name:
Column Name:
Year: 2012
Field Note:
 The 2012 birth file from Center for Health Statistics is preliminary and subject to change.
- Section Number:** Form17_Health Systems Capacity Indicator #04
Field Name: HSC04
Row Name:
Column Name:
Year: 2011
Field Note:
 2011 data are based on a provisional 2011 birth file. The 2011 birth file should be finalized in August 2013. These numbers are subject to change. If unknowns are excluded, the denominator changes to 376,881 and the percentage remains 65.3%.
- Section Number:** Form17_Health Systems Capacity Indicator #04
Field Name: HSC04
Row Name:
Column Name:
Year: 2010
Field Note:
 May 2012: Data for 2010 is finalized. If unknowns are excluded, the denominator changes to 378,772, making the percentage 64.3.

In 2005, Texas implemented the US Certificate of Live Birth, 2003. This change had a significant impact on measures of prenatal care utilization. Numerator estimates are based on a linear trend of data from 2005-2008 and denominator estimates are based on a linear trend of births from 1996-2008.

HEALTH SYSTEMS CAPACITY #07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

	<u>Annual Indicator Data</u>				
	2008	2009	2010	2011	2012
Annual Indicator	60.0	64.5	67.5	64.1	62.4
Numerator	1,311,475	1,484,899	1,749,012	1,845,144	1,832,873
Denominator	2,186,066	2,303,703	2,589,575	2,877,458	2,935,195
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07A

Field Name: HSC07A

Row Name:

Column Name:

Year: 2012

Field Note:

Time period covered for this measure is Federal Fiscal Year 2012. Age group is based on age at the end of the federal fiscal year. Numerator is the number of eligibles receiving at least one initial or periodic screening. Denominator is the number of individuals eligible who should receive at least one initial or periodic screen.

Source: Form CMS-416 Annual EPSDT Participation Report, FFY 2012.

2. **Section Number:** Form17_Health Systems Capacity Indicator #07A

Field Name: HSC07A

Row Name:

Column Name:

Year: 2011

Field Note:

Source: CMS-416 FFY2011

3. **Section Number:** Form17_Health Systems Capacity Indicator #07A

Field Name: HSC07A

Row Name:

Column Name:

Year: 2010

Field Note:

CMS-416 FFY2010

Reporting methods for the CMS-416 form were changed in FY2010. Prior to 2010, the total number of individuals eligible for any length of time served as the base population for the indicators reported. In 2010, the total number of individuals eligible for 90 continuous days served as the base population. The numerator and denominator are subsets of this population.

HEALTH SYSTEMS CAPACITY #07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

	<u>Annual Indicator Data</u>				
	2008	2009	2010	2011	2012
Annual Indicator	61.0	66.0	74.1	75.8	72.6
Numerator	357,067	415,490	483,967	529,945	523,639
Denominator	585,453	629,784	652,987	699,593	720,992
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.					
<i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Final	Final

Field Level Notes**1. Section Number:** Form17_Health Systems Capacity Indicator #07B**Field Name:** HSC07B**Row Name:****Column Name:****Year:** 2012**Field Note:**

Time period covered in report is Federal Fiscal Year 2012. Age group is based on age at the end of the federal fiscal year. Numerator is the number of eligibles ages 6-9 receiving any dental services. Denominator is the number of individuals ages 6-9 eligible for EPSDT for 90 continuous days.

Source: Form CMS-416 Annual EPSDT Participation Report, FFY 2012

2. Section Number: Form17_Health Systems Capacity Indicator #07B**Field Name:** HSC07B**Row Name:****Column Name:****Year:** 2011**Field Note:**

Source: CMS-416 FFY2011

3. Section Number: Form17_Health Systems Capacity Indicator #07B**Field Name:** HSC07B**Row Name:****Column Name:****Year:** 2010**Field Note:**

CMS-416 FFY2010

Reporting methods for the CMS-416 form were changed in FY2010. Prior to 2010, the total number of individuals eligible for any length of time served as the base population for the indicators reported. In 2010, the total number of individuals eligible for 90 continuous days served as the base population and is now reported as the denominator. The numerator is a subset of this population.

HEALTH SYSTEMS CAPACITY #08

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

	<u>Annual Indicator Data</u>				
	2008	2009	2010	2011	2012
Annual Indicator	22.0	22.4	30.6	33.7	25.9
Numerator	21,652	23,493	34,668	40,537	32,590
Denominator	98,409	104,971	113,432	120,274	125,607
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.)					
Is the Data Provisional or Final?				Final	Final

Field Level Notes**1. Section Number:** Form17_Health Systems Capacity Indicator #08**Field Name:** HSC08**Row Name:****Column Name:****Year:** 2012**Field Note:**

All SSI recipients in Texas obtain health care benefits coverage through Medicaid. Considering the broader spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach and case management services through CSHCN Title V efforts. Denominator is number of Texas SSI beneficiaries under 16 in December 2012.

2. Section Number: Form17_Health Systems Capacity Indicator #08**Field Name:** HSC08**Row Name:****Column Name:****Year:** 2011**Field Note:**

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

3. Section Number: Form17_Health Systems Capacity Indicator #08**Field Name:** HSC08**Row Name:****Column Name:****Year:** 2010**Field Note:**

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

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #05
(MEDICAID AND NON-MEDICAID COMPARISON)
STATE: TX

INDICATOR#05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
a) <i>Percent of low birth weight (< 2,500 grams)</i>	2012	Payment source from birth certificate	8.7	7.8	8.2
b) <i>Infant deaths per 1,000 live births</i>	2012	Payment source from birth certificate	5.7	5.7	5.5
c) <i>Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester</i>	2012	Payment source from birth certificate	54.5	70.4	62.1
d) <i>Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])</i>	2012	Payment source from birth certificate	61.8	70.2	65.8

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06 (MEDICAID ELIGIBILITY LEVEL)
STATE: TX

INDICATOR #06 <i>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</i>	YEAR	PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)
a) <i>Infants (0 to 1)</i>	2012	<input type="text" value="185"/>
b) <i>Medicaid Children</i> (Age range <input type="text" value="1"/> to <input type="text" value="5"/>) (Age range <input type="text" value="6"/> to <input type="text" value="18"/>) (Age range <input type="text"/> to <input type="text"/>)	2012	<input type="text" value="133"/> <input type="text" value="100"/> <input type="text"/>
c) <i>Pregnant Women</i>	2012	<input type="text" value="185"/>

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(SCHIP ELIGIBILITY LEVEL)
STATE: TX

INDICATOR #06 <i>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.</i>	YEAR	PERCENT OF POVERTY LEVEL SCHIP
a) <i>Infants (0 to 1)</i>	2012	<input type="text" value="200"/>
b) <i>Medicaid Children</i> (Age range <input type="text" value="1"/> to <input type="text" value="18"/>) (Age range <input type="text"/> to <input type="text"/>) (Age range <input type="text"/> to <input type="text"/>)	2012	<input type="text" value="200"/> <input type="text"/> <input type="text"/>
c) <i>Pregnant Women</i>	2012	<input type="text" value="200"/>

FORM NOTES FOR FORM 18

The 2012 Birth and Death files are not finalized, therefore linked data are not available. These data are subject to change.

FIELD LEVEL NOTES

1. **Section Number:** Form18_Indicator 05

Field Name: InfantDeath

Row Name: Infant deaths per 1,000 live births

Column Name:

Year: 2014

Field Note:

The 2012 birth and death File are not finalized, therefore a linked file is not yet available to match payee to each infant death. The rate for each payee was determined by taking the proportion of births paid for by medicaid and applying that to the total number of infant deaths to get the rates. The infant mortality rate for the entire state is lower than the rate for medicaid and non-medicaid payees because it includes births where the payee information was missing on the birth certificate.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TX

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Information)

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

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TX

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)*	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes
Other: Pregnancy/Risk Assessment Monitoring System (PRAM)	3	Yes
Behavioral Risk Factor Surveillance System (BRFSS)	3	Yes
Texas School Surveys	3	Yes

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:
1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

FORM NOTES FOR FORM 19

None

FIELD LEVEL NOTES

None

FORM 20
HEALTH STATUS INDICATORS #01-#05
MULTI-YEAR DATA
STATE: TX

Form Level Notes for Form 20

None

HEALTH STATUS INDICATOR #01A

The percent of live births weighing less than 2,500 grams.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	8.4	8.5	8.4	8.5	8.2
Numerator	34,230	34,157	32,490	32,718	32,114
Denominator	405,244	401,599	385,746	384,998	389,901

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

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2012

Field Note:

2012 birth data are preliminary and subject to change. Population estimates are from the Texas Data Center of the Office of the State Demographer.

2. **Section Number:** Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2011

Field Note:

2011 data are based on the provisional birth file. These data should be finalized in Aug 2013.

3. **Section Number:** Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2010

Field Note:

Update: 2010 natality data is final.

HEALTH STATUS INDICATOR #01B

The percent of live singleton births weighing less than 2,500 grams.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	6.7	6.7	6.7	7.0	6.5
Numerator	26,458	26,093	25,014	25,652	24,599
Denominator	392,755	388,736	373,694	364,802	377,420

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and

2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot

be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Field Level Notes1. **Section Number:** Form20_Health Status Indicator #01B**Field Name:** HSI01B**Row Name:****Column Name:****Year:** 2012**Field Note:**

2012 birth data are preliminary and subject to change. Population estimates are from the Texas Data Center of the Office of the State Demographer.

2. **Section Number:** Form20_Health Status Indicator #01B**Field Name:** HSI01B**Row Name:****Column Name:****Year:** 2011**Field Note:**

2011 data are based on the provisional birth file. These data will be finalized in Aug 2013

3. **Section Number:** Form20_Health Status Indicator #01B**Field Name:** HSI01B**Row Name:****Column Name:****Year:** 2010**Field Note:**

Update: 2010 natality data is final.

HEALTH STATUS INDICATOR #02A

The percent of live births weighing less than 1,500 grams.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	1.5	1.5	1.4	1.4	1.5
Numerator	5,924	5,952	5,575	5,529	5,691
Denominator	405,244	401,599	385,746	384,998	389,901

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and

2. The average number of events over the last 3 years is

fewer than 5 and therefore a 3-year moving average cannot

be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Field Level Notes1. **Section Number:** Form20_Health Status Indicator #02A**Field Name:** HSI02A**Row Name:****Column Name:****Year:** 2012**Field Note:**

2012 birth data are preliminary and subject to change. Population estimates are from the Texas Data Center of the Office of the State Demographer.

2. **Section Number:** Form20_Health Status Indicator #02A**Field Name:** HSI02A**Row Name:****Column Name:****Year:** 2011**Field Note:**

2011 data are based on the provisional birth file. These data will be finalized in Aug 2013.

3. **Section Number:** Form20_Health Status Indicator #02A**Field Name:** HSI02A**Row Name:****Column Name:****Year:** 2010**Field Note:**

Update: 2010 birth data are final.

HEALTH STATUS INDICATOR #02B

The percent of live singleton births weighing less than 1,500 grams.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	1.1	1.1	1.1	1.4	1.1
Numerator	4,335	4,387	4,662	5,128	4,265
Denominator	392,755	388,749	405,495	364,802	377,420

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and

2. The average number of events over the last 3 years is

fewer than 5 and therefore a 3-year moving average cannot

be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #02B**Field Name:** HSI02B**Row Name:****Column Name:****Year:** 2012**Field Note:**

2012 birth data are preliminary and subject to change. Population estimates are from the Texas Data Center of the Office of the State Demographer.

2. Section Number: Form20_Health Status Indicator #02B**Field Name:** HSI02B**Row Name:****Column Name:****Year:** 2011**Field Note:**

2006-2010 data are final.

2011 data are based on provisional birth file. These data will be finalized in Aug 2013.

3. Section Number: Form20_Health Status Indicator #02B**Field Name:** HSI02B**Row Name:****Column Name:****Year:** 2010**Field Note:**

Update: 2010 natality data are final.

HEALTH STATUS INDICATOR #03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	8.7	8.3	7.2	7.1	7.0
Numerator	471	452	413	409	403
Denominator	5,384,151	5,449,069	5,738,590	5,763,714	5,788,478

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and

2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot

be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional

Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03A

Field Name: HSI03A

Row Name:

Column Name:

Year: 2012

Field Note:

2012 death file is preliminary and subject to change. The population data are estimates from the Texas Data Center of the Office of the State Demographer.

2. **Section Number:** Form20_Health Status Indicator #03A

Field Name: HSI03A

Row Name:

Column Name:

Year: 2011

Field Note:

The 2011 death file is provisional. The data will be finalized in August 2013.

3. **Section Number:** Form20_Health Status Indicator #03A

Field Name: HSI03A

Row Name:

Column Name:

Year: 2010

Field Note:

Update: Death data for 2010 are final.

Denominator data from the Office of the State Demographer.

HEALTH STATUS INDICATOR #03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

	<u>Annual Indicator Data</u>				
	2008	2009	2010	2011	2012
Annual Indicator	3.5	3.4	3.0	2.7	3.6
Numerator	188	187	173	156	207
Denominator	5,384,151	5,449,069	5,738,590	5,763,714	5,788,478
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. <i>(Explain data in a year note. See Guidance, Appendix IX.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03B
Field Name: HSI03B
Row Name:
Column Name:
Year: 2012
Field Note:
 2012 data are from the preliminary death file and subject to change. The population estimates are from the Texas Data Center of the Office of the State Demographer.
2. **Section Number:** Form20_Health Status Indicator #03B
Field Name: HSI03B
Row Name:
Column Name:
Year: 2011
Field Note:
 The 2011 data are provisional and will be finalized in August 2013.
3. **Section Number:** Form20_Health Status Indicator #03B
Field Name: HSI03B
Row Name:
Column Name:
Year: 2010
Field Note:
 Update: Mortality data for 2010 is final.
 Denominator data provided by the Office of the State Demographer.

HEALTH STATUS INDICATOR #03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	<u>Annual Indicator Data</u>				
	2008	2009	2010	2011	2012
Annual Indicator	25.3	21.0	20.5	19.8	19.3
Numerator	937	788	757	732	715
Denominator	3,703,880	3,751,857	3,700,203	3,700,832	3,708,701
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. <i>(Explain data in a year note. See Guidance, Appendix IX.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Data Provisional or Final?				Provisional	Provisional

Field Level Notes

- Section Number:** Form20_Health Status Indicator #03C
Field Name: HSI03C
Row Name:
Column Name:
Year: 2012
Field Note:
 The 2012 death file is preliminary and subject to change.
- Section Number:** Form20_Health Status Indicator #03C
Field Name: HSI03C
Row Name:
Column Name:
Year: 2011
Field Note:
 The 2011 death file is provisional and will be finalized in August 2013.
- Section Number:** Form20_Health Status Indicator #03C
Field Name: HSI03C
Row Name:
Column Name:
Year: 2010
Field Note:
 Update: Mortality data for 2010 is final.
 Denominator data provided by the Office of the State Demographer.

HEALTH STATUS INDICATOR #04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	279.8	286.1	317.5	297.0	315.6
Numerator	15,067	15,590	16,248	17,120	18,268
Denominator	5,384,151	5,449,069	5,117,214	5,763,714	5,788,478

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and

2. The average number of events over the last 3 years is

fewer than 5 and therefore a 3-year moving average cannot

be applied.

*(Explain data in a year note. See Guidance, Appendix IX.)***Is the Data Provisional or Final?**

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #04A**Field Name:** HSI04A**Row Name:****Column Name:****Year:** 2012**Field Note:**

2012 is estimated based on a linear projection from 2008 to 2011.

2. Section Number: Form20_Health Status Indicator #04A**Field Name:** HSI04A**Row Name:****Column Name:****Year:** 2011**Field Note:**

2011 provided by the Texas Trauma registry.

3. Section Number: Form20_Health Status Indicator #04A**Field Name:** HSI04A**Row Name:****Column Name:****Year:** 2010**Field Note:**

Update: 2010 Trauma Registry data are final.

HEALTH STATUS INDICATOR #04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	42.5	38.7	43.8	38.2	38.8
Numerator	2,286	2,109	2,243	2,203	2,246
Denominator	5,384,151	5,449,069	5,117,214	5,763,714	5,788,478

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and

2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot

be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04B

Field Name: HSI04B

Row Name:

Column Name:

Year: 2012

Field Note:

2012 is an estimate based on a linear trend from 2008 to 2011.

2. **Section Number:** Form20_Health Status Indicator #04B

Field Name: HSI04B

Row Name:

Column Name:

Year: 2011

Field Note:

2011 data provided by the Texas Trauma Registry.

3. **Section Number:** Form20_Health Status Indicator #04B

Field Name: HSI04B

Row Name:

Column Name:

Year: 2010

Field Note:

Update: 2010 Trauma Registry data are final.

Denominator is the 2010 population from the Office of the State Demographer.

HEALTH STATUS INDICATOR #04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	167.8	155.8	158.4	160.0	155.3
Numerator	6,216	5,846	5,869	5,922	5,761
Denominator	3,703,880	3,751,857	3,704,504	3,700,832	3,708,701

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

*(Explain data in a year note. See Guidance, Appendix IX.)***Is the Data Provisional or Final?**

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #04C**Field Name:** HSI04C**Row Name:****Column Name:****Year:** 2012**Field Note:**

2012 data are estimated based on a linear trend with 2008-2011 data.

2. Section Number: Form20_Health Status Indicator #04C**Field Name:** HSI04C**Row Name:****Column Name:****Year:** 2011**Field Note:**

2011 data provided by the Texas Trauma Registry.

3. Section Number: Form20_Health Status Indicator #04C**Field Name:** HSI04C**Row Name:****Column Name:****Year:** 2010**Field Note:**

Update: 2010 Trauma Registry data are final.

Denominator is the 2010 population from the Office of the State Demographer.

HEALTH STATUS INDICATOR #05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	31.8	33.1	36.4	37.4	35.5
Numerator	28,928	30,350	33,296	32,955	32,307
Denominator	908,436	916,799	914,438	881,296	910,440

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.

<input type="checkbox"/>				
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(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05A

Field Name: HSI05A

Row Name:

Column Name:

Year: 2012

Field Note:

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are estimates from the Texas Data Center of the Office of the State Demographer.

2. **Section Number:** Form20_Health Status Indicator #05A

Field Name: HSI05A

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are projected by the Office of the State Demographer.

3. **Section Number:** Form20_Health Status Indicator #05A

Field Name: HSI05A

Row Name:

Column Name:

Year: 2010

Field Note:

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the Office of the State Demographer.

HEALTH STATUS INDICATOR #05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Annual Indicator Data

	2008	2009	2010	2011	2012
Annual Indicator	10.7	11.0	12.4	12.5	13.9
Numerator	46,526	48,639	56,576	58,286	61,930
Denominator	4,366,483	4,430,565	4,571,960	4,661,375	4,442,000

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and

2. The average number of events over the last 3 years is

fewer than 5 and therefore a 3-year moving average cannot

be applied.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Final

Provisional

Field Level Notes**1. Section Number:** Form20_Health Status Indicator #05B**Field Name:** HSI05B**Row Name:****Column Name:****Year:** 2012**Field Note:**

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are estimates from Texas Data Center of the Office of the State Demographer.

2. Section Number: Form20_Health Status Indicator #05B**Field Name:** HSI05B**Row Name:****Column Name:****Year:** 2011**Field Note:**

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are projected by the Office of the State Demographer.

3. Section Number: Form20_Health Status Indicator #05B**Field Name:** HSI05B**Row Name:****Column Name:****Year:** 2010**Field Note:**

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the 2010 Census data.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	397,802	285,786	46,191	0	0	0	0	65,825
Children 1 through 4	1,547,678	1,089,885	177,542	0	0	0	0	280,251
Children 5 through 9	1,933,666	1,356,676	224,513	0	0	0	0	352,477
Children 10 through 14	1,909,332	1,347,580	230,883	0	0	0	0	330,869
Children 15 through 19	1,869,019	1,320,793	241,463	0	0	0	0	306,763
Children 20 through 24	1,839,682	1,307,963	240,224	0	0	0	0	291,495
Children 0 through 24	9,497,179	6,708,683	1,160,816	0	0	0	0	1,627,680

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	198,378	199,424	0
Children 1 through 4	764,227	783,451	0
Children 5 through 9	971,141	962,525	0
Children 10 through 14	994,388	914,944	0
Children 15 through 19	1,015,530	853,489	0
Children 20 through 24	1,037,180	802,502	0
Children 0 through 24	4,980,844	4,516,335	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Provisional

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	568	354	92	0	0	0	0	122
Women 15 through 17	13,150	9,162	1,619	0	0	0	0	2,369
Women 18 through 19	27,954	19,403	3,830	0	0	0	0	4,721
Women 20 through 34	297,605	211,829	34,215	0	0	0	0	51,561
Women 35 or older	50,624	35,652	4,735	0	0	0	0	10,237
Women of all ages	389,901	276,400	44,491	0	0	0	0	69,010

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	158	410	0
Women 15 through 17	3,872	9,278	0
Women 18 through 19	10,687	17,267	0
Women 20 through 34	157,851	139,754	0
Women 35 or older	28,255	22,369	0
Women of all ages	200,823	189,078	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #08A - Demographics (Total deaths) Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Provisional

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	2,158	1,566	468	0	0	0	0	124
Children 1 through 4	459	341	86	0	0	0	0	32
Children 5 through 9	222	169	40	0	0	0	0	13
Children 10 through 14	285	219	40	0	0	0	0	26
Children 15 through 19	902	736	115	0	0	0	0	51
Children 20 through 24	1,779	1,379	315	0	0	0	0	85
Children 0 through 24	5,805	4,410	1,064	0	0	0	0	331

HSI #08B - Demographics (Total deaths) Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	933	1,225	0
Children 1 through 4	193	266	0
Children 5 through 9	110	112	0
Children 10 through 14	133	152	0
Children 15 through 19	387	515	0
Children 20 through 24	690	1,089	0
Children 0 through 24	2,446	3,359	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Provisional

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	7,657,496	5,400,720	920,591	0	0	0	0	1,336,185	2012
Percent in household headed by single parent	37.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2011
Percent in TANF (Grant) families	2.3	1.0	5.0	0.0	0.0	0.0	0.0	5.8	2012
Number enrolled in Medicaid	3,543,589	2,155,282	550,288	0	0	0	0	838,019	2012
Number enrolled in SCHIP	999,726	608,053	155,249	0	0	0	0	236,424	2012
Number living in foster home care	16,697	10,200	3,863	0	0	0	0	2,634	2012
Number enrolled in food stamp program	4,564,744	3,453,844	804,580	0	0	0	0	306,320	2012
Number enrolled in WIC	1,203,059	967,073	160,788	18,782	16,166	1,491	0	38,759	2012
Rate (per 100,000) of juvenile crime arrests	1,910.8	1,570.3	4,112.1	0.0	0.0	0.0	0.0	0.0	2011
Percentage of high school drop-outs (grade 9 through 12)	2.4	1.1	3.6	2.8	0.8	2.3	1.3	0.0	2011

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity. (Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	3,943,664	3,713,833	0	2012
Percent in household headed by single parent	2.0	2.7	0.0	2011
Percent in TANF (Grant) families	43.8	56.2	0.0	2012
Number enrolled in Medicaid	1,479,438	2,064,151	0	2012
Number enrolled in SCHIP	417,383	582,343	0	2012
Number living in foster home care	9,884	6,813	0	2012
Number enrolled in food stamp program	2,591,395	1,973,349	0	2012
Number enrolled in WIC	347,209	855,850	0	2012
Rate (per 100,000) of juvenile crime arrests	1,830.4	1,988.2	0.0	2011

Percentage of high school drop-outs (grade 9 through 12)

0.0

3.0

0.0

2011

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*

Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	1,387,502
Living in urban areas	4,616,773
Living in rural areas	716,015
Living in frontier areas	937,207
Total - all children 0 through 19	6,269,995

Note:

The Total will be determined by adding reported numbers for urban, rural and frontier areas.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	25,071,125
Percent Below: 50% of poverty	7.6
100% of poverty	18.5
200% of poverty	39.7

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	7,657,496
Percent Below: 50% of poverty	11.1
100% of poverty	26.6
200% of poverty	51

FORM NOTES FOR FORM 21

The State Demographer and most other indicators for Texas reports race/ethnicity as non-Hispanic White, non-Hispanic Black, Hispanic and other race. In order to match the race and ethnicity break-down requested here, the total number of Hispanics for that indicator was proportionally distributed in the race categories based on the way Hispanics self-identify their race in birth data from 2011 and 2012. About 76% of Hispanics identify as White, less than 1% as Black and the remaining as Other or multiple race.

This distribution was not done for Death and Birth data as it is not possible to separate race and ethnicity in these records.

The numbers of American Indians, Asians, Pacific Islanders and multiple race are not presented here separately because most programs in Texas do not break out these racial groups separately. So for consistency across all forms, they are included in the "other " category.

FIELD LEVEL NOTES

- Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2014
Field Note:
All data are from the Texas Data Center of the Office of the State Demographer. These population estimates for 2012 are based on the assumption of zero migration, therefore, may underestimate the true population.
- Section Number:** Form21_Indicator 07A
Field Name: Race_Women15
Row Name: Women < 15
Column Name:
Year: 2014
Field Note:
All data for 7A&7B are from the preliminary 2012 birth file and subject to change.
- Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2014
Field Note:
All data in 8A & 8B are from the preliminary 2012 death file and are subject to change.
- Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2014
Field Note:
American Community Survey from the Census Bureau. Data are the estimates combining data from 2007-2011 and are not available by race/ethnicity at this time.
- Section Number:** Form21_Indicator 09A
Field Name: HSIRace_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2014
Field Note:
Data provided by the Texas Health and Human Services Commission, Division of Strategic Decision Support
- Section Number:** Form21_Indicator 09A
Field Name: HSIRace_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2014
Field Note:
Data provided by Texas Health and Human Services Commission, Division of Strategic Decision Support.
- Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2014
Field Note:
Data provided by Texas Health and Human Services Commission, Division of Strategic Decision Support.
In the previous year the average monthly enrollment was reported due to limitations with obtaining the unduplicated client count for the entire year.
- Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2014
Field Note:

Data provided by Texas Health and Human Services Commission, Division of Strategic Decision Support. Data represent unduplicated client counts for the year. Due to reporting limitations, data for previous years were reported as the average monthly client count.

9. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_WCNo

Row Name: Number enrolled in WIC

Column Name:

Year: 2014

Field Note:

Data provided by Women, Infants, and Children Nutritional Program.

10. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_JuvenileCrimeRate

Row Name: Rate (per 100,000) of juvenile crime arrests

Column Name:

Year: 2014

Field Note:

The rate only represents children between 1-17 years. These data were provided by the Department of Public Safety.

11. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_DropOutPercent

Row Name: Percentage of high school drop-outs (grade 9 through 12)

Column Name:

Year: 2014

Field Note:

Data provided by the Texas Education Agency.

12. **Section Number:** Form21_Indicator 10

Field Name: Metropolitan

Row Name: Living in metropolitan areas

Column Name:

Year: 2014

Field Note:

From the Texas Data Center of the Office of the State Demographer.

NOTE: There is an error on the form and the population is not totaling correctly. The population total should be 7,957,497.

13. **Section Number:** Form21_Indicator 11

Field Name: S11_50percent

Row Name: Percent Below: 50% of poverty

Column Name:

Year: 2014

Field Note:

Poverty level data are from the American Community Survey from the Census Bureau using the following tables:

ACS > poverty > s1701 > 2011 for entire population at 50%, 100% (column), and 200% -

http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_S1701&prodType=table.

14. **Section Number:** Form21_Indicator 12

Field Name: S12_Children

Row Name: Children 0 through 19 years old

Column Name:

Year: 2014

Field Note:

Poverty data are from the American Communities Survey from the Census Bureau.

15. **Section Number:** Form21_Indicator 12

Field Name: S12_50percent

Row Name: Percent Below: 50% of poverty

Column Name:

Year: 2014

Field Note:

Note: Due to limitations in reporting of the data from the ACS, percentages are for children less than or equal to 18 years of age instead of 0 through 19 years of age.

The following form/table was used for these percentages:

ACS > poverty > s1703 > 2011 for children 0-18 at 50% and 100% -

16. **Section Number:** Form21_Indicator 12

Field Name: S12_200percent

Row Name: 200% of poverty

Column Name:

Year: 2014

Field Note:

The following data were used for the 200% poverty level:

Kids Count data center > Data Across States > View All Indicators A-Z > Children below 200% poverty -

17. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_FosterCare

Row Name: Number living in foster home care

Column Name:

Year: 2014

Field Note:

Data from Texas Department of Family Protective Services annual report.