



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

**State Narrative for
Texas**

**Application for 2012
Annual Report for 2010**



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I. General Requirements

A. Letter of Transmittal

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

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

B. Face Sheet

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

C. Assurances and Certifications

As per the Title V Block Grant Guidance expiring March 31, 2012, the appropriate assurances and certifications are being maintained Department of State Health Services central office and are available upon request. Please contact Sam Cooper at 512-458-7111, extension 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 March 2009; expires March 31, 2012.

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//

II. Needs Assessment

In application year 2012, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

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

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

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

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

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

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

health and quality of life outcomes of CYSHCN.

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

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

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

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

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

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//

Each of these geographic designations presents a unique service delivery challenge. In urban areas, services must meet the demands of a large, concentrated population. Service delivery challenges of rural area residents include the unavailability and inaccessibility of affordable health

care, lack of transportation, limited fiscal resources, little or no economic development, and the absence of trained healthcare professionals. While service needs may be similar between those residing in urban and rural areas, cultural norms and values may be different in urban and rural communities requiring outreach strategies uniquely tailored to each community. In the border region, challenges include limited infrastructure, a developed bi-national culture unique to the region, and cross-border utilization of services.

POPULATION

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

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

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

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

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

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.

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.

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.

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//

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-CYSHCN almost 17% of Texas CYSHCN under age 18 live in households below 100% of the Federal Poverty Level (FPL), as compared to the national average of 15.7%, and 20.9% of Texas CYSHCN under age 18 live in households between 100 -- 199% FPL, as compared to the national average of 19.1%. In total, approximately 38% of Texas CYSHCN under age 18 live in households with incomes below 200% FPL.

POPULATION DENSITY

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

POVERTY IN TEXAS

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

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

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

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//

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//

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//

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//

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//

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//

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

UNCOMPENSATED CARE

According to a report released by the Texas Department of State Health Services entitled, Charity Care Charges and Selected Financial Data for Acute Care Texas Hospitals, 2008, there was over \$13 billion dollars of uncompensated care in Texas in 2008. This accounted for 9.2% of the total gross patient revenue. Of this \$13 billion, 44.9% was from bad debt and the remaining 55.1% was

for charity care. Between 1999 and 2008, uncompensated care increased by nearly 179% in Texas. In 2008, 33.9% of the uncompensated care was provided by public hospitals, 44.5% was provided by nonprofit hospitals and 21.6% was provided by for-profit hospitals.

ACCESS TO CARE

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

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

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

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

DIRECT PATIENT CARE PHYSICIANS

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

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

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//

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//

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.

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.

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.

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//

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.

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.

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.

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

TEXAS STATUTES RELEVANT TO TITLE V

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

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

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

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

communication and cognitive skill development.

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

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

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

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

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

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

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

DSHS TITLE V CAPACITY

A. Overview of Programs and Services

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

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

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

The majority of Title V services are provided through contracts with local providers including

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

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

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

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

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

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

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

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.

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//

Office of Academic Linkages -- Identifies and 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.

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.

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.

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.

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.

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.

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

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

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

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

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

guidance. All participate in the MHWG and all are active in providing community-based services to CYSHCN and their families.

a. Rehabilitation services for CYSHCN receiving SSI

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

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

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

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

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

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

B. Culturally Competent Care

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

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

Most educational materials for children and women are published or made available in at least English and Spanish, and frequently in other languages based on need. Referral information

provided through 2-1-1 Texas is provided 24 hours a day, 7 days a week in multiple languages. In many cases, there are Spanish speaking operators. For the other languages, 2-1-1 Texas contracts with either Tele-Interpreter or the AT&T Language Line. Services are also available through text telephone or TTY for people with hearing impairments.

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

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

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.

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.

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.

The Chief Financial Officer is Machele 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//

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.

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.

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

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

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

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

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

HSCMU administers federally-mandated preventive health services (EPSDT) to Medicaid eligible clients from birth through 20 years of age through the Texas Health Steps program. Client

services include medical and dental care and case management. HSCMU also develops and administers mandated screening programs, including spinal, vision, lead, and hearing as well as case management services all supported by Title V.

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

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

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

D. Other MCH Capacity

NUMBER AND LOCATION OF STAFF WORKING IN TITLE V PROGRAMS

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

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

SENIOR LEVEL MANAGEMENT BIOGRAPHIES

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

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

Emilie Becker, MD, has served as Medical Director for Behavioral Health in the DSHS MHSA Services Division since June 2009. She provides support and guidance to the medical directors at the state hospital facilities and serves as a consultant, advising on behavioral health-care issues, to community mental health centers and local providers of substance abuse services. Previously,

Dr. Becker was attending physician at Austin State Hospital and acting medical director at the Austin Travis County Mental Health and Mental Retardation and was the child psychiatrist for its Child and Adolescent Emergency Team. Dr. Becker has worked at the Bellevue Hospital in New York, in juvenile corrections settings, and had a private practice. Dr. Becker has training in child and adolescent psychiatry, as well as forensic psychiatry.

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

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//

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

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

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

Board of Pediatrics and the American Board of Medical Genetics. Dr. Freedenberg authored and co-authored more than 22 published articles in various academic journals.

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

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

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

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.

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.

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

Mike Montgomery is the Director of the Nutrition Services Section in FCHS since 2001. He provides overall direction, policy development, and policy enforcement for WIC and the Farmers' Market Nutrition Program. Previously, he led the Texas WIC project development team for the Electronic Benefits Transfer (EBT) project and was Chief of the Bureau of Nutrition Services before leading the Children's Health Bureau. Mr. Montgomery has more than 30 years experience with WIC, having served across the spectrum of management and administration in

positions at the federal, state, and local level including 22 years with the USDA's Food and Nutrition Service. Mr. Montgomery has a Bachelor of Science degree from the State University of New York with majors in Sociology and Psychology.

TENURE OF STATE MCH WORKFORCE

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

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

PROJECTED CHANGES TO WORKFORCE IN THE COMING YEAR

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

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

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

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

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

E. State Agency Coordination

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

ORGANIZATIONAL RELATIONSHIPS AMONG HHS SYSTEM

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

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

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

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

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

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

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

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

With the potential for overlap of Medicaid, CHIP, and DSHS programs, an executive team has been established through the DSHS Office of Priority Initiatives Coordination (OPIC). The purpose of OPIC is to provide support to the DSHS Commissioner's Office to ensure that the vast array of legislative mandates, exceptional item funding, and agency priority projects are identified, resourced, and managed in a manner that meets DSHS' obligations to partners, clients, stakeholders, and oversight agencies. Most recently, agency leadership established the DSHS Medicaid Executive Management Team to ensure proactive cross-agency communication, collaboration, and risk/issue management related to the following three areas: Medicaid Policy, Texas Health Steps (EPSDT), and other Medicaid-related efforts.

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

Opportunities which support collaborative efforts for interagency collaboration include:

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

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

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.

CSHCN SP staff represents DSHS on the Children's Policy Council. The Children's Policy Council assists HHS agencies in developing, implementing, and administering family support policies and related long-term care and health programs for children. Membership is composed primarily of family members of consumers and is supported by state agencies such as HHSC, DSHS, and DFPS. The Council provides recommendations to the state legislature on issues such

as: access of a child or a child's family to effective case management services; transition needs of children who reach an age at which they are no longer eligible for services; collaboration and coordination of children's services and the funding of those services between state agencies; and effective permanency planning for children who reside in institutions or who are at risk of placement in an institution.

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

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

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

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

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

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

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

profit agencies, and individual providers.

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

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

RELATIONSHIP TO PROFESSIONAL EDUCATION PROGRAMS AND UNIVERSITIES

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

DSHS MCH and CSHCN SP staff partner with Baylor College of Medicine, the LEAH grantee for Texas, on a variety of initiatives. LEAH works to improve the health and well-being of adolescents through education, research, program and service model development, evaluation, and dissemination of best practices. CSHCN SP staff participates on the planning committee for and attends the LEAH Program's annual Chronic Illness and Disability Conference. Title V contracts with LEAH to provide: scholarships for family members of CSHCN 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).

An attachment is included in this section. III E - State Agency Coordination

F. Health Systems Capacity Indicators

Introduction

The Health Status Capacity Indicators (HSCIs) for Texas identify areas of great improvement and areas in need of attention. The rate of children hospitalized for asthma ranged from a low of 23.7 per 10,000 children in 2009 to a high of 28.4 per 10,000 children in 2006. This decline represents both a cost savings to the Texas health care systems and an improvement in the area of preventive health. Since 2006, 100.0% of Medicaid enrolled infants received at least one initial periodic screen. In addition to these successes, the HSCIs identified areas for improvement in Texas. Indicators for prenatal care, low birth weight, and infant mortality all lag behind 2010 objectives. There is also a significant disparity between Medicaid and non-Medicaid populations. To address these indicators, Texas continues to explore outreach methods for enrolling participants in Medicaid and CHIP including activities of Title V-funded contractors and regional DSHS staff. In addition to expanded coverage, Texas has conducted and shared the results of a Perinatal Periods of Risk Analysis, has funded several projects aimed at addressing disparities in the adequacy of prenatal care, and has analyzed and promulgated results of Texas PRAMS. Texas will continue to use data to inform initiatives and interventions that will reduce the disparities in these indicators and contribute to achieving internal state targets and national Healthy People 2010 and future Healthy People 2020 objectives.

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 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	28.4	27.7	24.1	25.6	28.8
Numerator	5349	5284	4642	4986	4549
Denominator	1881855	1906500	1927981	1951170	1581862
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 - 2010

Data Source: Texas Hospital Inpatient Discharge Public Use Data File.

The numerator estimates for 2010 are based on a linear projection using data from 2000 through 2009. The data is based on hospitalizations. Therefore, one person may account for multiple hospitalizations. The reported data may underestimate the true rate of hospitalization for asthma because Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the Texas Health Care Information Council (THCIC).

Denominator data are projected by the Office of the State Demographer (TxSDC). Projections of the 2010 population are produced by TxSDC using a model of projected births and deaths, rather than actual records. Both estimation and projection models use estimates of migration rates produced by the TxSDC. The Texas Health and Human Services Commission (HHSC) has designated the "2000 - 2007 Scenario" to be the current standard for HHSC agency population projections. The 2000-2007 projection scenario provides a scenario that takes into account post-2000 population trends.

(http://txsdc.utsa.edu/tpepp/2008projections/2008_Texas_County_Projection_Methodology.pdf)
Current population estimates developed through 2009 using actual records (births, deaths, school

enrollment, voter registration, etc) have revealed that population projections using the 2000-2007 scenario may be an underestimate. As a result, indicators using 2010 population projections as a denominator are likely to be overestimated.

Notes - 2009

Data Source: Texas Hospital Inpatient Discharge Public Use Data File.

This indicator has been adjusted for final data.

The data is 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.

Notes - 2008

Data Source: Texas Hospital Inpatient Discharge Public Use Data File.

The data is 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 2010 objective is to reduce hospitalization for asthma in children 0 to 5 years of age to 25 per 10,000 or less. In 2008, the rate of hospitalizations per 100,000 declined to 24.1 per 100,000. Projections for 2009 indicate that the rate of asthma hospitalizations in Texas will remain below the 2010 objective.

The Texas environment is challenging for persons with asthma. Texas is home to a diverse mix of air pollutants. The Gulf Coast region is home to one of the largest petrochemical complexes in the world. Many Texas cities have grown dramatically over the past 20 years increasing the numbers of automobiles and trucks on Texas roads. These factors coupled with the high number of days with sunshine, contribute to air pollution in most of our cities. The documented declines from the year 2000 can be attributed to the Asthma Coalition of Texas, in which the DSHS is an active participant. The work of the Asthma Coalition of Texas focuses on six issues :

1) Infrastructure and collaborations: building a network of asthma stakeholders and partners to carry out asthma activities statewide, regionally and at the community level and development of local community based coalitions to address asthma.

2) Surveillance: to maintain, improve and expand asthma surveillance in Texas, including identifying health disparities and under-diagnosed populations.

3) Clinical management of asthma: increase the use of evidence-based and best practice guidelines for the diagnoses, treatment and management of asthma by all health care professionals to optimize health care delivery to all individuals.

4) Education: expansion and improvement of quality asthma education to ensure consistency with the National Asthma Education and Prevention Program Guidelines, development of culturally competent and health literate resources regarding asthma, and development of public awareness campaign to increase understanding of asthma.

5) Community and public health policy: development of policies and programs to target asthma in the following areas: asthma in schools, work related asthma, health system change, environment, and public policy.

6) Health disparities and access to care: addressing and striving to eliminate the unequal burden of asthma among racial and ethnic minorities and medically underserved populations through data collection, development of culturally competent resources and target interventions based on needs identified through data collection.

In addition to the work of the Asthma Coalition of Texas, research literature has demonstrated that appropriate management by primary care providers can help avoid asthma hospitalizations. Title V will continue to work toward a decline in the number of children hospitalized for asthma in Texas.

//2012/ The rate of hospitalization for asthma in children 0 to 5 years of age increased to 25.6 per 10,000 in 2009. Projections for 2010 indicate that the rate of asthma hospitalizations in Texas will exceed the 2010 objective. The Texas Asthma Control Program at DSHS notes that the increase in hospitalizations is not due to one cause, but factors such as lack of self-management education and misdiagnosis or delayed diagnosis may play a part. DSHS will explore further over the next year. //2012//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	100.0	100.0	81.8	81.3	92.9
Numerator	258808	259222	197019	194131	158750
Denominator	258808	259222	240911	238927	170927
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

Notes - 2010

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.

Notes - 2009

CMS-416 FFY2009

Incorrect numerator data was reported in Block Grant Applications prior to FY12. Data from 2008-2009 have been corrected.

Notes - 2008

Texas CMS-416 FFY 2007 - 2008

Incorrect numerator data was reported in Block Grant Applications prior to FY12. Data from 2008-2009 have been corrected.

Prior to 2008, Medicaid service data could not be unduplicated due to the design of the data collection system. As a result, numerator data in 2006 and 2007 exceeded the denominator.

Corrected annual indicators for 2006-2007:

2006 = 261,999 (Numerator)/258,808 (Denominator) = 101.2%

2007 = 259,222 (Numerator)/254,196(Denominator) = 102.0%

Narrative:

In 2005, 96.4 percent of Medicaid enrollees aged less than one year received at least one initial periodic screen. In 2006-2009, 100.0 percent of Medicaid enrollees aged less than one year received at least one initial periodic screen. Preventive care that starts early is essential to the lifelong health of an individual and this capacity indicator bodes well for the health of Texas' children. The improvement in this measure may be attributable to the enhanced efforts of the Texas version of the EPSDT program, Texas Health Steps, to inform caretakers of newly certified individuals on the value of preventive services. This outreach stresses the value of a medical home, the importance of preventive care, and active assistance in scheduling medical, dental and transportation services.

//2012/ Data reported in 2006-2007 is inaccurate due to data collection methods and cannot be corrected. Approximately 81% of Medicaid enrollees under the age of one received at least one initial periodic screen in 2008-2009. A 14.3% increase in the proportion of Medicaid enrollees who received at least one periodic screen was observed between 2009 and 2010, although some of this increase may be due to a change in reporting methods in 2010. //2012//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	38.5	42.1	70.6	71.7	75.7
Numerator	1243	944	45208	64065	68729
Denominator	3226	2243	64026	89369	90795
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

Notes - 2010

Source: Texas Health and Human Services Commission (HHSC).

Notes - 2009

Source: Texas Health and Human Services Commission (HHSC).

Notes - 2008

Source: Texas Health and Human Services Commission (HHSC).

Narrative:

Although the percentage of children who are less than 1 year of age and on SCHIP who receive at least one periodic screen was similar for 2008 and 2009, the actual number of infants increased substantially during that time period. It took approximately a year for an increase in the CHIP Perinatal program to occur. These years differed dramatically from previous years due to changes in the enrollment requirements. The 78th Texas Legislature in 2003 made changes to the eligibility enrollment requirements. These changes include: 1) decreasing the continuous coverage period from 12 months to six months; 2) increasing premiums for families above 100% FPL and cost-sharing for families below 185% FPL; 3) elimination of income deductions for items such as child care costs; and 4) implementing a 90-day waiting period for coverage. In addition to changes at the state level, new federal regulations require enrollees in CHIP to provide affirmation of their identity and their income. While these regulations may aid in the identification of families who are no longer eligible for services, they may erect a barrier to enrollment.

//2012/ An increase in the proportion of SCHIP enrollees under one year of age who received at least one periodic screen increased from 71.7% in 2009 to 75.7% in 2010. Although the percentage of children who are less than 1 year of age and on SCHIP who receive at least one periodic screen was similar for 2008 and 2009, the actual number of infants increased substantially during that time period. //2012//

In 2007, the 80th Texas Legislature revised the CHIP eligibility and enrollment requirements to return the coverage period to 12 months, reinstate income deductions for dependent care, and eliminate the 90-day waiting period. The changes took effect on 9/1/07. These changes led to an increase in the proportion of SCHIP enrollees less than one year of age who received at least one periodic screening. The increase between 2006 and 2007 surpassed the decline between 2005 and 2006. The continuation of the CHIP Perinatal Program, which provides prenatal services to women who are ineligible for Medicaid to improve the health of the infant, increased access to and participation of services that benefit the eligible infants.

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 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	62.0	64.0	59.4	60.4	58.0
Numerator	242388	258337	240687	242458	243034
Denominator	390702	403690	405242	401610	419224
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 - 2010

All natality data reported for 2010 is estimated. 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.

Notes - 2009

All natality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Notes - 2008

All natality data reported for 2008 is final. This indicator has been adjusted for final data.

Narrative:

Among projected figures for resident births in 2009 for women ages 15-44, the percentage with adequate or better prenatal care was 67.8%, which was an increase from 2005. Title V funds contractors to provide accessible, high quality, culturally competent prenatal care across Texas. However, despite this support, the supply of health care providers to fully serve the at-risk population is less than the demand. Several Texas counties have no health care providers that offer these services. In other cases, providers may not be fully cognizant of the needs of the population, especially as the demographics of Texas are changing due to an influx of new populations with diverse needs. Women's health care systems may not be working in an integrated, comprehensive manner, so appropriate and timely referrals are not made or necessary follow up does not occur. DSHS will engage medical residency programs in discussions regarding the National Health Service Corps and loan repayment programs, and continue to use the Conrad 30 J-1 Visa Waiver Program to help rural and underserved areas recruit foreign physicians. Title V continues to work to identify solutions and strategies with stakeholders to aid early enrollment into prenatal care.

//2012/ Among projected figures for resident births in 2010 for women ages 15-44, the percentage with adequate or better prenatal care was 58.0%, which was a decrease from 2006.

The Healthy Texas Babies Initiative includes activities and interventions based on current research that strive to improve birth outcomes in Texas, such as preterm birth, low birth weight, and infant mortality. //2012//

This continues to be a challenging indicator for Texas at this time. Currently, the most recent final natality file available in Texas is 2006. In 2005, Texas implemented the new 2003 US Certificate of Live Birth, which changed the manner in which prenatal care data were collected. While projections for 2007, 2008, and 2009 are provided, these projections cannot appropriately account for the impact of the implementation of the new birth certificate based on only two years of data. The implementation of the CHIP Perinatal Program also occurred after 2005. Therefore, current data cannot measure the impact of this program and, as it is a new program, it cannot be adequately addressed through projections. As the prenatal care landscape continues to change in Texas and more recent data become available, it will be important to assess the impact that these changes had on this indicator to determine future policy and programmatic directions.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010

Annual Indicator	64.5	65.6	60.0	64.5	67.5
Numerator	1370299	1405344	1311475	1484899	1749012
Denominator	2123317	2142033	2186066	2303703	2589575
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

Notes - 2010

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.

Notes - 2009

Source: Texas CMS-416 FFY 2009.

Notes - 2008

Source: Texas CMS-416 FFY 2008.

Narrative:

Between 2005 and 2009, the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program increased from 62.9% (2005) to 64.5% (2009), an increase of 2.5%. The percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program has exceeded 60% since 2003. The Title V program monitors this figure annually as part of the grant development process. A contributor to the increase is the practice in Title V-funded contractors throughout the state of screening and referring children who are potentially eligible for Medicaid and CHIP. With the increased outreach among the patient population and training offerings to the Medicaid provider population, continued increases are expected in this measure. Statewide efforts continue to perform outreach and informing activities for clients; to provide education and training about Texas Health Steps; and to use other innovative efforts to increase the number of services provided. There are currently 40 modules available online for providers regarding Texas Health Steps education and training. The award-winning online program offers free CE Courses to enhance providers' ability to provide preventive health, mental health, oral health and case management services to Medicaid eligible children in Texas. An example of the innovative efforts include the Children's Medicaid Loan Repayment Program for physicians and dentists who provide care to children on Medicaid, as well as other initiatives that focus on improving access to medical and dental benefits.

//2012/ Between 2006 and 2010, the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program increased from 64.5% (2006) to 67.5% (2010), an increase of 4.7%, although some of this increase may be due to reporting changes between 2009 and 2010. Two additional modules are now available online for providers regarding Texas Health Steps education and training for a total of 42 current modules. //2012//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	55.2	58.1	61.0	66.0	74.1
Numerator	308987	330435	357067	415490	483967
Denominator	559406	569106	585453	629784	652987
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

Notes - 2010

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.

Notes - 2009

Source: Texas CMS-416 FFY 2009.

The incorrect numerator was entered for 2009 in the previous application. This number has been corrected.

Notes - 2008

Source: Texas CMS-416 FFY 2007 - 2008.

Narrative:

Between 2005 and 2009, the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year increased from 56.3% (2005) to 62.6% (2009), an increase of 11.2%. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year has exceeded 55% since 2003. This improvement is attributable to several factors, including but not limited to, enhanced outreach and information, and scheduling and transportation assistance efforts provided through the Texas version of the EPSDT program, Texas Health Steps. These outreach efforts have focused on the fact that early access to preventive dental services can decrease the level of dental disease experienced by this population group and have generated an increasing number of inquiries from clients and their caregivers about oral health. Allowances have been made to increase the reimbursement rate for dental providers. Additional participation increases are expected in coming years as Medicaid dental reimbursement rates may increase. Two dental strategic initiatives were implemented in 2008. The goal of the First Dental Home (FDH) initiative, implemented in March 2008, is to promote the concept of establishing a dental home for all class members in the target population enrolled in Texas Health Steps. The FDH initiative provides opportunities for early intervention and prevention of dental disease. The goal of the Oral Evaluation and Fluoride Varnish in the Medical Home Initiative, implemented in September 2008, is to work with Texas Health Steps medical checkup providers to introduce class member parents/caregivers to the importance of early dental care.

//2012/ The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year increased to 74.1% in 2010, an increase although some of the increase may be attributable to reporting changes between 2009 and 2010. //2012//

Health Systems Capacity Indicator 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.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	25.1	23.0	22.0	22.4	30.6
Numerator	21088	21145	21652	23493	34668
Denominator	83891	91874	98409	104971	113432
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

Notes - 2010

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.

Notes - 2009

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.

Notes - 2008

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.

Narrative:

All SSI recipients in Texas obtain health care benefits through Medicaid. In considering the overall spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach, intake, case management and other support services through DSHS central and regional staff. The percentage decreased some in 2006 due to standardizing the definition and reporting of case management services. However, the percentage has stabilized over the last few years. In Texas, CYSHCN includes children from birth up to age 21; therefore the count of SSI recipients served by DSHS staff may include some SSI recipients who are 16 through 20 years of age, although these recipients are thought to represent a very small percentage of the whole.

//2012/ An increase was seen between 2009 and 2010, from 22.4% to 30.6%. The increase in the percentage of clients receiving rehabilitative services may be explained by improved

reporting, data collection methods, and queries of the TWICES data management system. The increase may also be due to the economic downturn, with a subsequent increase in unemployment/underemployment rates contributing to increased utilization. //2012//

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)	2008	payment source from birth certificate	9.2	7.8	8.4

Notes - 2012

Source: 2008 Final Natality File

Narrative:

in both groups continue to exceed the Healthy People 2010 Objective of 5%. The percent of infants born low birth weight increased overall by 1.8% from 2005. The Medicaid population experienced a greater increase in the percentage of infants born low birth weight (2.3%) than the Non-Medicaid population (1.6%) from 2005 to 2006.

//2012/ In 2008, the rates of low birth weight were 17.9% higher in the Medicaid population than in the non-Medicaid population. The percent of infants born low birth weight decreased overall by 1.2% from 2006 to 2008. The Medicaid population experienced a decrease in the percentage of infants born low birth weight (3.3%) while the non-Medicaid population experienced an increase (1.3%) from 2006 to 2008. //2012//

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

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
Infant deaths per 1,000 live births	2008	payment source from birth certificate	6.1	5	5.4

Notes - 2012

Infant mortality reported here differs from the infant mortality rate reported for 2008 from Form 12, Outcome Measure 1. This occurs because only infants deaths for which a matching birth certificate can be identified are included in the numerator.

Source: Matched Final 2008 Natality File and 2008 Mortality File.

Narrative:

Regardless of Medicaid status, the infant mortality rates among all groups exceeded the Healthy People 2010 Objective of 4.5 infant deaths per 1,000 live births. However, the overall rate in

Texas and the rate among non-Medicaid participants were lower than the national rate in 2006, and was the same for the Medicaid participants (6.7 infant deaths per 1,000 live births). The infant mortality rate was 24.1% higher among Medicaid participants. The infant mortality rates decreased overall from 2005 to 2006 and for the Medicaid and non-Medicaid populations. Planning focused on sleep safety for infants, including collaboration with the Texas Department of Family and Protective Services (DFPS) continued in FY09 through a cross agency work group called the Infant Health Workgroup. In addition, DSHS has partnered with DFPS on two safe sleep projects, including an online training for CPS caseworkers in assessing a sleep environment for safety when working with a family. This training will be required of CPS caseworkers and supervisors. The second project is a pilot project and includes a train-the-trainer targeting community level providers working with families. In addition to these projects, the Information for Parents of Newborns booklet about SIDS prevention and safe sleep is available on the DSHS website. Activities promoting safe sleep practices, especially in low-income populations, may help to reduce the overall infant mortality rate and the disparity between Medicaid and non-Medicaid participants.

//2012/ The Medicaid, non-Medicaid, and overall rates in Texas continued to be lower than the national rate in 2007 (6.75 infant deaths per 1,000 live births). Final 2008 national data is not currently available. The infant mortality rate was 22% higher among Medicaid participants. The infant mortality rates decreased overall from 2006 to 2008 and for the Medicaid and non-Medicaid populations.

Planning continued in 2010 with the cross agency Infant Health Workgroup. DSHS has also joined with external partners for the Healthy Texas Babies Initiative, which includes activities and interventions based on current research that strive to improve birth outcomes in Texas, such as preterm birth, low birth weight, and infant mortality. //2012//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

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 infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	48.5	65.8	57.9

Notes - 2012

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

Source: 2008 Final Natality File

Narrative:

While the change in the birth certificate in Texas in 2005 impacts multi-year measures, assessing the relative differences between groups should not be impacted by this change. The proportion of women enrolled in Medicaid who received first trimester care was 25.4% lower than women not enrolled in Medicaid. This gap has been increasing over the past several years. Both the Medicaid and non-Medicaid populations fail to meet the 90% standard set in Healthy People 2010. Future activities need to continue to focus on outreach and informing activities specific to

the Medicaid population and to improve pregnancy planning.

/2012/ Data from the 2008 Final Natality file indicates that the proportion of women enrolled in Medicaid who received first trimester care was 35.7% lower than women not enrolled in Medicaid. //2012//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

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 pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	53.5	64.4	59.4

Notes - 2012

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

Source: 2008 Final Natality File

Narrative:

While the change in the birth certificate in Texas in 2005 impacts multi-year measures, assessing the relative differences between groups should not be impacted by this change. The proportion of women enrolled in Medicaid who received adequate prenatal care was 11.7% lower than women not enrolled in Medicaid as determined by the Kotelchuck Index. The gap in prenatal care use between non-Medicaid and Medicaid populations is less when using the Kotelchuck Index compared to enrollment in the first trimester. This may suggest that while women receiving Medicaid do not enter prenatal care early, once entered, they receive the adequate number of visits.

/2012/ As determined by the Kotelchuck Index, 2008 Final Natality data indicates that the proportion of women enrolled in Medicaid who received adequate prenatal care was 20.4% lower than women not enrolled in Medicaid. //2012//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2010	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP	YEAR	PERCENT OF POVERTY LEVEL

programs for infants (0 to 1), children, Medicaid and pregnant women.		SCHIP
Infants (0 to 1)	2010	200

Narrative:

Medicaid eligibility in Texas surpasses the Federal Medicaid mandate of 133% FPL. CHIP further expands coverage to infants whose families are 200% FPL or below are eligible for CHIP in Texas. This standard is the most common eligibility standard throughout the country.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2010	133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2010	200

Narrative:

Eligibility requirements for children ages 1 through 5 satisfy minimum acceptable standards established by federal Medicaid regulations. Texas also includes coverage for children 6 through 18 and in situations of extreme poverty also covers young adults ages 19 and 20, neither of which is mandated by federal Medicaid regulations. Children ages 1 through 19 whose families are 200% FPL or below are eligible for CHIP in Texas. This standard is the most common throughout the country.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2010	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2010	200

Narrative:

Texas provides Medicaid coverage to pregnant women by exceeding the federally mandated 133% FPL and allowing coverage up to 185% FPL. Since FY07, CHIP also provides care to pregnant women up to 200% FPL who are not eligible for Medicaid.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (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)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	2	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
<u>REGISTRIES AND SURVEYS</u> 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

Notes - 2012

Narrative:

Infant Birth and Death Certificates

DSHS currently has the capacity to link birth and death records and perform analyses for program planning and policy formulation purposes. DSHS has the responsibility for vital statistic registration in Texas. Data are readily available.

/2012/ Data are readily available; however, there is a significant time lag of 2-3 years to receive final vital statistics data. This time lag affects all linkages involving vital statistics data. //2012//

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims files

DSHS currently has the capacity to link birth records and Medicaid data. Texas requires significant time/resources to manage/link the data due to 400,000 births and millions of Medicaid eligibility records and/or claims generated per year.

Annual linkage of birth certificate and WIC eligibility files
 DSHS currently has the capacity to link birth certificate and WIC data. WIC data are readily accessible and birth record extracts for PRAMS are linked monthly to improve contact information of potential respondents in order to increase response rates.

Annual Linkage of birth certificate and newborn screening files
 Texas Newborn Screening currently tests for 28 disorders. Texas Early Hearing Detection and Intervention (TEHDI) Program is the State's universal newborn hearing screening, tracking and intervention program. Hospitals with obstetric services and birthing facilities with 100 or more births per year located in counties with population >50,000 are legislatively mandated to offer newborn hearing screening.

Hospital Discharge Surveys
 The Texas Health Care Information Council (THCIC) has responsibility for collecting hospital discharge data from all state licensed hospitals except those that are statutorily exempt from reporting requirements (those located in counties with a population <35,000 or counties with a population >35,000 but <100 licensed hospital beds). The data are administrative rather than clinical. Final data files are ~2 years behind and contain ~95% of all hospital discharges. Linking to Hospital Discharge data is not legal in Texas.

Annual Birth Defects Surveillance
 Texas Birth Defects Registry is a population-based registry, which collects statewide data on pregnancies affected by birth defects. The registry is based upon active surveillance of infants and fetuses with birth defects born to Texans. The Registry became statewide starting with 1999 births. Records based on abstracted medical information are matched to vital records filed with the vital records.

PRAMS
 The Pregnancy Risk Assessment Monitoring System (PRAMS) is a CDC sponsored initiative to reduce infant mortality and low birth weight. PRAMS is an on-going state specific population-based surveillance system designed to identify and monitor selected maternal experiences before, during and after pregnancy. A sample of ~200 mothers is drawn monthly from the birth records. PRAMS uses mixed mail and telephone modes to conduct interviews with biological mothers of infants aged 60-180 days old. Texas initiated PRAMS in 2002, and is currently one of 38 states participating.

//2012/ Texas is currently one of 37 states participating. //2012//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

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
Behavioral Risk Factor Surveillance System (BRFSS)	3	Yes
Pregnancy Risk Assessment Monitoring System (PRAMS)	3	Yes
Texas School Surveys	3	Yes

Notes - 2012

Narrative:

Youth Risk Behavior Survey

Current Status: The Youth Risk Behavior Survey (YRBS) is one component of the CDC epidemiologic surveillance system developed to monitor the prevalence of youth behaviors that influence health. DSHS has direct access to and the capacity to analyze this database. YRBS is conducted biennially in selected metropolitan areas and only students in the 9th-12th grade in private and public schools are sampled. Therefore results may not be representative of non-metropolitan areas and data cannot be used for regional estimates.

Texas School Survey

Current Status: Texas Commission on Alcohol and Drug Abuse (TCADA) in collaboration with the Public Policy Research Institute at Texas A&M University conducted two statewide surveys of drug and alcohol use among students in elementary and secondary schools. Reports of these surveys are currently available for 1988 through 2006. Surveys are only conducted in public schools therefore private school students and dropouts are not represented in the sample. Estimates of substance use in this survey are based on self-reports.

//2012/ Reports of these surveys are currently available for 1998 through 2010. Previous information indicating reports were available beginning in 1988 was an error. //2012//

Behavioral Risk Factor Surveillance System

Current Status: The Behavioral Risk Factor Surveillance System (BRFSS) is one component of the CDC epidemiologic surveillance system developed to monitor the prevalence of behaviors among adults (ages 18 and older) that influence health. For the 2007, 2008, 2009 and 2010 BRFSS administration in Texas, questions were added that addressed breastfeeding, family planning, and oral health. DSHS has direct access to and the capacity to analyze these data. Additional funding has allowed for oversampling among Texas' border populations which should yield new information useful to programs. All data are self reported through telephone interviews.

//2012/ Questions on tobacco use are included in the BRFSS questionnaire annually. //2012//

PRAMS

Current Status: While DSHS has direct access to these data, Texas PRAMS does not currently meet CDC's requirement of a 65% response rate per sample strata. The response rate for Texas PRAMS in 2008 was 64.5%. Texas hopes to make it into the national sample in 2009 and will continue to explore ways to increase participation rates. PRAMS data are collected statewide and available data cannot be used for regional or local estimates. All data are self-reported. Currently, data analyses are being conducted internally to influence policy and service delivery in the Title V program.

//2012/ In 2009, Texas PRAMS had a sufficient response rate (67%) to meet CDC's requirement of a 65% response rate per sample strata to be included in the national sample for the first time. //2012//

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 fetoinfant 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	2006	2007	2008	2009	2010
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	370	433	470	524	554
Denominator	370	433	470	524	554
Data Source			Newborn Screening Database	Newborn Screening Database	Newborn Screening Database
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance Objective	100	100	100	100	100

Notes - 2010

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

Notes - 2009

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

Notes - 2008

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

a. Last Year's Accomplishments

Activity 1: There were 392,640 initial newborn screening specimens, with 1,379 (0.35%) found unsatisfactory. There were 9,250 contacts made for unsatisfactory specimens. The DSHS Newborn Screening program (NBS) distributed education materials including 396 Weight Conversion Charts, 69 Specimen Collection Guides, 41 Spot Check Guides, 19 ACT/FACT sheets, 11 Specimen Collection Posters, 119 Newborn Screening specimen submitter packets, and 34 CD Slide Presentations. 14 NBS overview presentations and CF training modules were provided with a total of 176 attendees.

Activity 2: Education efforts included distribution of 149,880 NBS brochures, 102 NBS posters, and 5,060 bookmarks. There were 542,659* visits to the NBS website. In addition, 1,906 health care providers accessed NBS online education modules and 615 new web-based system users have been added for NBS online services.

Since December 2007, NBS has been notifying families of newborn children identified as having sickle cell trait. Families receive a certified letter from NBS as well as an educational/resource booklet. In FY10, 4,054 Sickle Cell Trait letters and informational booklets were mailed to families.

*Figure is calculated using a new web based program that includes hits to pdf files not previously included in web totals.

Activity 3: Revisions to the booklet were completed in November 2009. Information on SIDS and Safe Sleep were added. The revised booklet was made available in English and Spanish in print and on the MCH website, http://www.dshs.state.tx.us/mch/pdf/info_for_parents.pdf. The English brochure had 18,239 page views last year and the Spanish brochure had 5,246 page views.

Activity 4: Stakeholder meetings were held in November 2009 (Bandera), February 2010 (Ft. Worth), May 2010 (San Antonio), and August 2010 (Austin). Final approval for 21 performance measures (PMs) to be piloted in FY10 was received. At the February 2010 meeting, the team members began exploring interventions for the issues identified in the NBS Program. The completed PM Report was sent to the Centers for Disease Control and Prevention (CDC) in January 2010. Database queries for the 21 PMs to be piloted were moved to the Laboratory Information Management Systems server. The 21 PMs were piloted for effectiveness in improving time to treatment for infants with NBS disorders. The pre-analytical universal newborn screening report card was designed, automated, and validated. The stakeholders identified and performed feasibility studies on interventions that are likely to improve the NBS system and address quality issues. A request to CDC for an 8 month no cost extension of unobligated carry forward funds from Year 2 to Year 3 was granted in September 2010. The objectives of the extension include completing the pilot studies, identifying and publishing the evidence-based interventions, and documentation through final project reports.

Performance Assessment: Between 2008 and 2010, NBS met the annual objective of 100% follow up and case management of identified presumptive positives. This was accomplished with increased awareness of the legal requirements for NBS and continued technical assistance to minimize the number of unsatisfactory tests.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures.			X	
2. Educate parents, 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.			X	
3. Revise the Office of Title V publication Information for Parents of Newborns and make available on the MCH web page.			X	
4. Identify tangible 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 193,864 initial newborn screening (NBS) specimens, with 959 found to be unsatisfactory. 6,446 contacts were made to submitters with unsatisfactory specimens. Education materials including 96 Weight Conversion Charts, 139 Specimen Collection Guides, 101 Spot Check Guides, 15 ACT / FACT sheets, 74 Newborn Screening Specimen Submitter Packets, 30 CD Slide Presentations and 23 Neonatal Screening brochures were distributed.

Activity 2: Education efforts included distribution of 68,570 NBS Brochures, 180 NBS posters, and 1413 bookmarks. 2,010 Sickle Cell Trait Letters and booklets were mailed. There were 270,254 web-based encounters, 525 NBS providers and other health care professionals accessed and completed NBS, Sickle Cell Disease and Trait, and Sickle Cell Trait education modules, and 213 new users were added.

Activity 3: The Information for Parents of Newborns continues to be posted online and available in print in English and Spanish. The mailbox continues to be available.

Activity 4: The TX NBS Performance Measures (PM) Project will pilot the PM and research interventions. The pre-Analytical Universal Report Card (RC) was developed and a web-based application of it was tested. The post-analytical disorder specific RC was developed and distribution discussed. The team met with stakeholders in January, and sent a survey to other U.S. NBS Programs for input on interventions.

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) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures.

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

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

tracking of dissemination of materials.

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

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

Monitoring: Document distribution of materials and interactions with stakeholders.

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

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

Monitoring: Ensure 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 and post-analytical stages of the newborn screening process.

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

Monitoring: Track progress at regularly scheduled steering committee meetings.

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:	392516							
Reporting Year:	2010							
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.	No.	No.	%	

Phenylketonuria (Classical)	390611	99.5	99	9	9	100.0
Congenital Hypothyroidism (Classical)	390611	99.5	7787	219	219	100.0
Galactosemia (Classical)	390611	99.5	631	3	3	100.0
Sickle Cell Disease	390611	99.5	170	139	139	100.0
Biotinidase Deficiency	390611	99.5	355	41	41	100.0
Cystic Fibrosis	390611	99.5	371	59	59	100.0
Homocystinuria	390611	99.5	126	0	0	
Maple Syrup Urine Disease	390611	99.5	107	2	2	100.0
beta-ketothiolase deficiency	390611	99.5	0	0	0	
Tyrosinemia Type I	390611	99.5	74	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	390611	99.5	103	9	9	100.0
Argininosuccinic Acidemia	390611	99.5	79	2	2	100.0
Citrullinemia	390611	99.5	0	1	1	100.0
Isovaleric Acidemia	390611	99.5	316	1	1	100.0
Propionic Acidemia	390611	99.5	0	1	1	100.0
Carnitine Uptake Defect	390611	99.5	587	4	4	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	390611	99.5	221	10	10	100.0
Methylmalonic acidemia (Cbl A,B)	390611	99.5	203	3	3	100.0
Multiple Carboxylase Deficiency	390611	99.5	0	0	0	
Trifunctional Protein Deficiency	390611	99.5	0	0	0	
Glutaric Acidemia Type I	390611	99.5	156	7	7	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	390611	99.5	4296	29	29	100.0
Medium-Chain	390611	99.5	205	14	14	100.0

Acyl-CoA Dehydrogenase Deficiency						
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	390611	99.5	44	0	0	
3-Hydroxy 3-Methyl Glutaric Aciduria	390611	99.5	0	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	390611	99.5	0	1	1	100.0
Hearing Screening	2609444		43489	0	0	
Vision Screening	2701769		227621	0	0	
Spinal Screening	727942		22527	0	0	

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	57.4	57.5	58	58.1	58.2
Annual Indicator	57.0	57.9	57.9	57.9	57.9
Numerator	142384	450786	450786	450786	450786
Denominator	249840	778339	778339	778339	778339
Data Source			National Survey of CSHCN	National Survey of CSHCN	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
	2011	2012	2013	2014	2015
Annual Performance Objective	58.3	58.4	58.5	58.6	58.6

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 NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

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

Notes - 2008

Indicator data comes 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. Numerator and denominator are weighted estimates.

a. Last Year's Accomplishments

Activity 1: CSHCN Services Program (SP) contractors and central office and regional staff reported attending 374 stakeholder meetings with participation by 6,317 family members. Key areas of interest for families included emergency preparedness and disaster planning, the Individual Education Plan (IEP) process, legal services, and behavior/mental health services. Paso del Norte Children's Development Center partnered with a mental health collaborative and presented a Mental Health Academy for Families. Texas Parent to Parent launched an online support group specifically for fathers. The Children's Special Needs Network's Annual Conference included a "father's panel" to engage dads. CSHCN SP contractors collaborated with community organizations to provide supports for military families including person-centered training and respite.

CSHCN SP contractors held workshops and programs for parents on issues including: support groups, emergency preparedness and disaster planning, sensory integration, guardianship, behavior/mental health, legal services, medical transportation, and more.

Activity 2: CSHCN SP staff regularly solicited information from families to gauge satisfaction with services and obtain recommendations for improvement. A standardized measurement for all contractors was obtained by implementing four core questions for the FY10 contractor family satisfaction surveys. 1,588 family surveys were evaluated. 1,538 (96.8%) reported overall satisfaction with contractor services; 1,515 (95.4%) were satisfied with access to services and information; 1,542 (97.1%) were satisfied with customer service; and 1,566 (98.6%) were satisfied with family involvement in planning, delivery, and decision-making.

Activity 3: CSHCN SP revised the detail and format of information about the CYSHCN Title V Performance Measures to help families better understand and identify with the objectives. CSHCN SP staff participated in the Title V Five-Year Needs Assessment Public Forums.

Surveys gathered data from parents and families of CYSHCN as part of the Title V Five-Year Needs Assessment process and indicated a substantial need for transition services, respite, other family supports, and help in using community-based service systems. Families indicated a high level of satisfaction with partnering in decision-making and felt connected with the state service system. This data was included in one of two reports developed by CSHCN SP staff to detail the methods and findings from provider and parent surveys and parent focus groups conducted as part of the needs assessment process.

Performance Assessment: The 2005/06 National Survey of CSHCN (NS-CSHCN) reported that 57.9% of Texas families of CYSHCN aged 0-18 responded that they are partners in decision making and are satisfied with the services they receive. The data indicated that Texas was on par with the national average. CSHCN SP contractor client/family surveys consistently reported high levels of overall satisfaction (97%) with case management, clinical services, and family supports or community resource services. DSHS sought ongoing family input and participation in decision-making through stakeholder meeting reports, contractor reporting, parent focus groups, surveys, parent conferences, and collaboration with Family Voices representatives.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support and enhance mechanisms for partnering in decision-making with families of CSHCN and promoting family networking.				X
2. Monitor consumer satisfaction with CSHCN Services Program contractor services.				X
3. Assess consumer satisfaction with CSHCN SP health care benefits and with state service systems in general.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: CSHCN Services Program (SP) contractors and staff attended 146 stakeholder meetings with participation by 2,667 family members. Priority concerns included the state budget deficit and wait lists for services. Staff also participated in the development of the Children's Policy Council's biennial report submitted to the Texas Legislature and assisted the Emergency Medical Services for Children (EMSC) State Partnership toward improving pediatric emergency service delivery.

Texas Parent to Parent (TxP2P) was honored by the MCHB as a champion in improving systems of care for CSHCN and families. TxP2P worked with EMSC on assessment and management training. TxP2P began building a statewide advocacy network to engage families, youth, and siblings in the legislative process.

Activity 2: 627 family surveys were evaluated. 627 (100%) reported an overall satisfaction rate of contractor services; 626 (99.8%) are satisfied with access to services and information; 627 (100%) are satisfied with customer services; and 625 (99.6%) are satisfied with family involvement in planning, delivery, and decision-making.

Activity 3: CSHCN SP contractors surveyed families using the methodology utilized for the Title V 5 Year Needs Assessment. Input will be compared to previous data and used in decision-making and planning.

The Task Force for Children with Special Needs distributed a survey and held public hearings to identify and address priority issues for CSHCN and their families.

An attachment is included in this section. IVC_NPM02_Current Activities

c. Plan for the Coming Year

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

Output Measure(s): Monitoring documentation of CYSHCN/ family electronic mail distribution lists and key stakeholder groups with significant CYSHCN/ family membership (including contractor advisory groups); documentation of staff and contractor participation in stakeholder groups with significant CYSHCN/family membership; documentation of training and other efforts to promote family involvement and partnership in decision-making at state, local, and individual levels.

Monitoring: Information from electronic mail distribution lists, Stakeholder Meeting Records and regional meeting/events data, contractor quarterly reports of priority concerns/suggestions relevant to CYSHCN and their families; program discussions and use of family inputs in decision-making and activity planning, staff reporting of training and other efforts.

Activity 2: Monitor consumer satisfaction with CSHCN Services Program (SP) contractor services.

Output Measure(s): Indicators of level of satisfaction with CSHCN SP contractor services such as contractor quarterly satisfaction survey results and the percentage of their clients who are satisfied with core topic areas as well as other services they receive through the contractor and "Priority concerns/suggestions relevant to CYSHCN" from the contractor Stakeholder Meeting section of quarterly report; recommendations/input to contractors from consumers; and contractor response to consumer feedback.

Monitoring: Review contractor quarterly reports.

Activity 3: Assess consumer needs and satisfaction pertaining to health care benefits and state service systems.

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	58.7	58.8	46.4	46.5	46.6
Annual Indicator	58.3	46.3	46.3	46.3	46.3
Numerator	399631	351768	351768	351768	351768
Denominator	685206	759974	759974	759974	759974
Data Source			National Survey of CSHCN	National Survey of CSHCN	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
	2011	2012	2013	2014	2015
Annual Performance Objective	46.7	46.8	47	47.1	47.1

Notes - 2010

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

Notes - 2009

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

Notes - 2008

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

a. Last Year's Accomplishments

Activity 1: The Medical Home Workgroup (MHWG) met quarterly with active discussion of activities, initiatives, and updates to the strategic plan. Those attending meetings presented numerous medical home activities which were documented in meeting minutes. CSHCN SP staff sent medical home materials for Child Health Day to the MHWG distribution list. Additional Medical home information is available statewide via the website which had 103,393 hits.

The Title V CYSHCN Director joined the Texas team that participated in the National Academy for State Health Policy (NASHP) multi-state medical home consortium and provided input for the development of the Texas Medicaid Health Home Pilot for children.

The director also collaborated with the Texas Medical Home Initiative, a non-profit entity facilitated by the American College of Physicians in partnership with medical providers, insurers, employers, and other stakeholders, to develop a demonstration project that incorporates a transition-focus in the first pilots of the patient-centered medical home for adults.

Title V funds were used for contracts with physician practice sites implementing services that support the provision of a medical home for CYSHCN. The CSHCN Services Program (SP) approved and implemented 6 proposals for "Medical Home Supports" to enhance services for CYSHCN, including a family-centered in-depth needs assessments; a resource guide with a transition module; a youth-led project to create a Transition Notebook; proactive care coordination and education to reduce emergency room visits and hospitalizations; an enhanced Electronic Medical Record workflow tool to ensure patients receive preventative care; a mobile clinic and community partnership to develop a medical home; and a transition clinic in partnership with medical subspecialties. A required component for funding was the implementation of Emergency Information Forms for CYSHCN.

Title V provided continued funding to partner with the Baylor College of Medicine Leadership Education in Adolescent Health (LEAH) program. LEAH supported 49 family members' attendance and participation in the annual transition conference; recruited/trained 35 physicians in 13 clinics to implement and evaluate a "transition module" in the electronic medical record for Texas Children's Hospital's pediatric clinics; and recruited and assisted 13 internal medicine residents to complete a transition clinic rotation. Dr. Cynthia Peacock, founder of the Transition Clinic which provides a medical home to adolescents with chronic illnesses or disabilities aging out of pediatric medical care, was selected as Houston Mayor's Disability Advocate of the Year for 2010.

586 health care professionals completed the Texas Health Steps Medical Home training module which includes information on the National Committee for Quality Assurance Medical Home Recognition standards. CSHCN SP staff provided comments and assisted with beta-testing for an update to the module.

Activity 2: CSHCN SP contractors and regional staff assisted 1,039 families receiving case management in finding a medical home. Families and providers were educated on the concept of a medical home through conferences, grand rounds, and medical residency programs. Regional training specialists in North Texas conducted medical home training for the Bridge to Health Mobile Clinic and Head Start nurses.

87.1% of CYSHCN receiving case management and clinical services from CSHCN SP regional staff and contractors had a primary care provider (PCP). Of the 2,806 CSHCN who had a primary care provider, 2,712 (96.6%) had seen their PCP within the past 12 months.

Performance Assessment: The 2005/06 NS-CSHCN reported that 46.3% of Texas CYSHCN aged 0-18 received coordinated, ongoing, comprehensive care within a medical home. This is somewhat below the national average. The measure was not comparable across survey years due to changes in survey questions. Increasing awareness and access to a medical home were priorities for CSHCN SP. The MHWG, medical home supports funding, and major Texas initiatives have increased awareness of the medical home concept for families, physicians, third party payors, state agency personnel, and others.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide leadership to, and collaborate with members of the Medical Home Workgroup (MHWG), to increase awareness and knowledge of the medical home concept and to promote the implementation of medical home projects and quality improvements.				X
2. CSHCN Services Program regional staff and contractors help CSHCN link to medical homes.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The Medical Home Work Group (MHWG) meets quarterly with discussion of multiple activities and updates to the strategic plan. Topics include: Emergency Medical Services for Children, Medical Home Supports grant overviews, Medicaid Buy-in for Children, and Health Information Regional Extension Centers.

MHWG members: Dr. Carl Tapia, Baylor College of Medicine and Texas Children's Hospital Special Needs Primary Care Clinic, was appointed by Gov. Rick Perry to the Pharmaceutical and Therapeutics Committee which makes recommendations about the preferred drug lists adopted by HHSC; Dr Cynthia Peacock was named 2010 Houston Mayor's Disability Advocate of the year.

Activity 2: CSHCN Services Program (SP) staff members serve on the Traumatic Brain Injury task

force to promote integration Medical Home and mental health/behavioral health.

177 CSHCN SP contractors and other health care professionals completed the Introduction of Medical Home Texas Health Steps training module.

Activity 3: Contractors and regional staff assisted 753 families in finding a medical home.

The MHWG documents the progress of the Medicaid Health Home Project which has been delayed indefinitely due to budget constraints. The Texas Medical Home Initiative (TMHI) kicked off the demonstration project.

A major medical home initiative for FY11 includes continuation of the Baylor College of Medicine's LEAH project to increase access to coordinated and integrated care as youth transition to adult services.

An attachment is included in this section. IVC_NPM03_Current Activities

c. Plan for the Coming Year

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

Output Measure(s): Progress on MHWG strategic plan, MHWG minutes, and 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 Provider Bulletin and Family Newsletter; presentation schedule (conferences, seminars, and other venues); website postings to primary websites - CSHCN SP website and Texas page of AAP medical home website, and other relevant websites; development and dissemination of materials/tools information.

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

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

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

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

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

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

on integration of dental and mental health services.

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	54	54.1	58.3	58.4	58.5
Annual Indicator	52.9	58.2	58.2	58.2	58.2
Numerator	366173	462528	462528	462528	462528
Denominator	692198	795137	795137	795137	795137
Data Source			National Survey of CSHCN	National Survey of CSHCN	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
	2011	2012	2013	2014	2015
Annual Performance Objective	58.6	58.7	58.8	58.9	58.9

Notes - 2010

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

Notes - 2009

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

Notes - 2008

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

a. Last Year's Accomplishments

Activity 1: Enhancements were made to the Medicaid Online Provider Lookup and Provider Enrollment Portal systems. The site, which incorporates CSHCN Services Program (SP) providers and is used by CSHCN SP staff and clients with health care benefits, became fully functional with expanded capabilities to offer more ways to find an appropriate doctor, dentist, or other provider.

CSHCN SP collaborated with Medicaid and Texas Health Steps to provide preventive care

medical services to CYSHCN. The Health and Human Services Commission (HHSC) developed a Medicaid Buy-In program for children with disabilities and special health care needs up to age 19 with a targeted implementation date of January 1, 2011. HRSA awarded the HHSC \$50 million to provide cost sharing accounts to help low-income working Texans earning up to 300% FPL to buy insurance.

HHSC solicited proposals for a Medicaid Health Home Pilot project to improve access to care for children enrolled in Medicaid and increase the number of children receiving primary medical, dental, and specialty services.

HHSC contracted with Texas Tech Health Science Center to give children with Medicaid in rural areas more access to specialists. HHSC also contracted with UT Southwestern to establish Texas PASS, the Texas Pediatric Access to Subspecialists project: a phone-based consultation and referral service offering primary care physicians access to UT Southwestern specialists 24 hours a day, 7 days a week. UT Medical Branch/Galveston's telepsychiatry network expanded to 11 local MHMR centers to improve access for children up to 18 years of age with Medicaid.

The Texas Youth Empowerment Services (YES) Medicaid waiver pilot began providing services in two counties to youth ages 3-18 with serious emotional disturbances. YES allows for more flexibility in the funding of intensive community--based services and supports.

A CSHCN SP community-based contractor participated in a collaboration to provide a free dental clinic for CYSHCN who did not have dental insurance.

Activity 2: During FY10, 2,211 children received CSHCN SP health care benefits and 255 children were released from the waiting list. As of August 31, 2010, 1,488 children were on the waiting list for health care benefits due to funding limitations. Of these children, 466 had no other health care coverage. CSHCN SP assisted 25 families with insurance premium payments. DSHS regional staff and CSHCN SP contractors assisted families with CHIP, Medicaid, and CSHCN SP applications to prevent coverage lapses.

Activity 3: Staff exhibited at conferences and responded to inquiries about Medicaid/CHIP, Medicaid Waivers, and CSHCN SP benefits to help families and providers access resources. CSHCN SP contractors participated in conferences and health fairs to help families access health care.

Baylor College of Medicine's Leadership Education in Adolescent Health (LEAH), a CSHCN SP contractor, provided stipends for 49 parents/family members to attend the 2010 annual transition conference and learn about accessing health care for their youth aging out of pediatrics into adult health care.

The CSHCN SP Family Newsletters and Provider Bulletins included articles on accessing specialists, hospice services, medical transportation, prescription drugs, and more.

Performance Assessment: In the 2005/06 NS-CSHCN, 58.2% of Texas CSHCN aged 0-18 reported having adequate private and/or public insurance to pay for needed services. Data suggested that Texas is moving in the right direction with regard to this measure; however, the state continued to fall below the national average of 62%. Recent implementation of the Medicaid Buy-In program and the YES Waiver provided additional opportunities for access to health care coverage for CYSHCN. To stay within budget alignment for health care benefits, the number of children provided CSHCN SP health care benefits fell by 5.7% from FY09 to FY10 and the number on the waiting list increased by 26%.

Table 4a, National Performance Measures Summary Sheet

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

	DHC	ES	PBS	IB
1. Pursue opportunities to collaborate with Texas Medicaid, CHIP, and other public/private health benefits providers and agencies to maximize health care coverage and quality assurance parameters of such coverage for CSHCN.				X
2. Maximize the provision of CSHCN Services Program (SP) health care benefits to eligible clients.	X	X	X	X
3. Provide information on public and private health insurance and financing of health care for CSHCN to families of CSHCN and providers and coordinate with Medicaid and CHIP to provide this information in their provider/family publications.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: CSHCN Services Program (SP) staff participated in developing the Healthy Texas Program, a lower cost health insurance plan for small employers.

DSHS revised provider qualifications and service descriptions for YES Waiver services to increase the ability for providers to participate.

Activity 2: During the 1st half of FY11, 1,733 children received CSHCN SP health care benefits. As of February 28, 2011, 1,335 children were on the waiting list for these benefits. Of these children, 574 had no other health care coverage. CSHCN SP assisted 24 families with insurance premium payments. DSHS regional staff and CSHCN SP contractors assisted families with CHIP, Medicaid, and CSHCN SP applications to access benefits and prevent coverage lapses.

CSHCN SP developed a process to more accurately identify children eligible for Emergency Medicaid to conserve resources and maximize the number of children receiving health care benefits.

CYSHCN received Family Support Services including respite, home, and van modifications. Budget restrictions limited home and van modifications.

Activity 3: CSHCN SP conducted outreach and presented on the implementation of MBIC. Staff developed and distributed information packets to families, contractors, and providers via e-mail and newsletters to assist with the application process. Packets were distributed to health care benefits clients identified as likely eligible for Medicaid Buy-In for Children.

An attachment is included in this section. IVC_NPM04_Current Activities

c. Plan for the Coming Year

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

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

Monitoring: Documentation of progress made on collaborative efforts; ongoing identification of

Federal Health Care Reform developments and assessment of impact for CYSHCN.

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

Output Measure(s): Number of CSHCN SP health care benefits clients by age (i.e. ongoing clients, received CSHCN SP health care benefits, on the waiting list, on the waiting list with no other source of insurance, removed from the waiting list); number of CSHCN SP health care benefits clients who received Insurance Premium Payment Assistance (IPPA); number of CSHCN SP clients/families provided home modifications through the CSHCN SP family support services (FSS); number of CSHCN SP clients/families provided van modifications through the CSHCN SP FSS; documentation of efforts to increase number of CSHCN SP providers and outcomes of those efforts.

Monitoring: Review monthly CSHCN SP health care benefits client and provider data (from Texas Medicaid Health Care Partnership (TMHP) and program quarterly data summary reports).

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

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

Monitoring: Review contractor quarterly reports; program articles published; and other means of communication.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	77.2	77.3	88.3	88.4	88.5
Annual Indicator	76.8	88.2	88.2	88.2	88.2
Numerator	193670	706914	706914	706914	706914
Denominator	252253	801141	801141	801141	801141
Data Source			National Survey of CSHCN	National Survey of CSHCN	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
	2011	2012	2013	2014	2015
Annual Performance Objective	88.6	88.7	88.8	88.9	88.9

Notes - 2010

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

Notes - 2009

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

Notes - 2008

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

a. Last Year's Accomplishments

Activity 1: Finding Help in Texas, the state's 2-1-1 website, has been redesigned to make it easier to learn about state and local services. (The upgraded website has a simplified design and more user-friendly features, including a list of top search subjects and quick links to the most frequently sought state agency websites and applications.) People made approximately 214,319 Maternal and Child Health related calls to the 2-1-1 system in FY10, a 65% increase from FY09, which may be indicative of increased needs due to the economic downturn. The CSHCN Services Program (SP) website usage data showed the site was accessed 582,408 times.

Activity 2: The Texas Legislature mandated a statewide Task Force for Children with Special Needs and charged it with creating a strategic plan to improve the coordination, quality, and efficiency of services for children with a chronic illness, intellectual or other developmental disability, or serious mental illness. The DSHS Assistant Commissioner for Family and Community Services was appointed a member and was made the chairperson for the Health Subcommittee. The Title V CYSHCN Director has been a member of the Health Subcommittee and presented to the Task Force. Another CSHCN SP staff member was appointed to the Transition Subcommittee.

CSHCN SP staff was active in interagency efforts that included the Community Resource Coordination Groups State Work Group meetings and the Traumatic Brain Injury Advisory Council. Staff edited a section of the Governor's Committee on Disabilities Report. Staff and contractors collaborated with community organizations to provide information, education, training, case management, and other community resources to families of CYSHCN.

A CSHCN SP contractor, Texas Parent to Parent, held an annual conference with more than 400 families attending. They learned about many topics, including People First Language skills and emergency preparedness for CYSHCN. The conference included an extensive session allowing parents to share information and network with one another.

HHSC and the Department of Aging and Disability Services (DADS) developed a website making it easier to search for long-term care services provided by Medicaid. The website included customer satisfaction information for Medicaid plans offering long-term care services. DADS developed online information on the roles and responsibilities of those in the Consumer Directed Services Medicaid option that hire and manage the individuals who provide services.

Activity 3: 1,478 professionals completed the Texas Health Steps Cultural Competence training module. CSHCN SP contractor staff had a 100% completion rate for completing the Cultural Competence training module.

The CSHCN SP Family Newsletter, published quarterly in English and Spanish, included publications about flu prevention and emergency and disaster planning for CYSHCN.

The CSHCN SP Family Newsletter separately published, "What does 'intellectual disability' mean?" to educate families on respectful language and modern terminology, including efforts to replace the words "retarded" and "retardation" with "intellectual disabilities."

Activity 4: CSHCN SP contractors and regional staff provided case management services for 18,772 CYSHCN in FY10. Professionals completed the following additional Texas Health Steps training modules relevant for CSHCN: 886 Case management, 659 Mental Health, and 659 Mental Health Disorders.

Activity 5: CSHCN SP staff developed a targeted information activity for sharing successful initiatives and practices during quarterly contractor conference calls. These communications led to substantive exchange of information and community resource solutions among contractors across the state.

Performance Assessment: The 2005/06 NS-CSHCN indicated that 88.2% of Texas families of CYSHCN aged 0-18 reported that community-based services are organized so they can use them easily, slightly less than the national average. CSHCN SP staff and contractors continued efforts to improve easy access to community-based services through collaboration with other state and community-based partners. Client/family surveys provided through CSHCN SP contractors in FY10 consistently reported high levels of satisfaction with case management, clinical services, and family supports or community resource services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Texas Information and Referral / 2-1-1 system to foster effective linking of CSHCN and their families to community services and supports.				X
2. Participate in interagency and intra-agency efforts to assess and improve state policies and programs that impact CSHCN and their families.				X
3. Continue and enhance use of appropriate languages, cultural approaches, and literacy level in publications and other interactions with CSHCN Services Program consumers.			X	
4. Provide case management through CSHCN Services Program.		X		
5. Enhance and promote collaboration among CSHCN Services Program Contractors.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Over 162,114 calls were made to the 2-1-1 system by mid-FY11.

Activity 2: Staff represented the interests of CYSHCN and families on workgroups including the Children's Policy Council, Task Force for Children with Special Needs, and Texas Respite Coalition. Staff assisted in the development of workgroup biennial reports and recommendations to the legislature.

Texas Parent to Parent updated its website and resource directory making it easier for families to find and access services.

386 health care professionals completed the Texas Health Steps Case Management Services module.

Activity 3: The CSHCN SP Family Newsletter included an article on the passage of 'Rosa's Law.' Texas legislators introduced bills relating to the use of person first respectful language. People First Language, appropriate literacy levels, and Spanish translation are used in communication with contractors, providers, and stakeholders.

1,123 health care professionals completed the Texas Health Steps cultural competence module.

Activity 4: CSHCN SP contractors and regional program staff provided case management, family supports, and community resources to 7,716 clients.

Activity 5: CSHCN SP staff held monthly contractor calls to provide technical assistance, share success stories, and spread innovation.

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 foster and improve effective awareness and linkage to community services and supports for CYSHCN and their families.

Output Measure(s): 2-1-1 Texas service requests related to maternal and child health; efforts to maintain and increase 2-1-1 family resources; increased 2-1-1 staff understanding of CYSHCN issues; documentation of information and referrals (I&R) from regional staff and contractors.

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

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.

Output Measure(s): Groups in which CSHCN SP staff and contractors actively participate; review of Stakeholder Meeting Records to identify key issues, needs, and recommendations and inform Title V activity planning; completion of the DSHS Case Management training module by CSHCN SP staff, contractors, and others.

Monitoring: Review Stakeholder Meeting Records, contractor quarterly reports, annual Title V Activity Plan; DSHS training module data.

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.

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

Monitoring: Review media, staff activities, DSHS training module completion data, contractor technical assistance, site observations, communications, and quarterly reports.

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

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

Monitoring: Review contractor and regional quarterly activity reports and CSHCN SP health care benefits family support services data.

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

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	5.8	5.8	37.2	37.3	37.4
Annual Indicator	5.8	37.1	37.1	37.1	37.1
Numerator		107424	107424	107424	107424
Denominator		289879	289879	289879	289879
Data Source			National Survey of CSHCN	National Survey of CSHCN	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
	2011	2012	2013	2014	2015
Annual Performance Objective	37.5	37.6	37.7	37.8	37.9

Notes - 2010

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

Notes - 2009

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

Notes - 2008

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

a. Last Year's Accomplishments

Activity 1: CSHCN Services Program (SP) regional staff and contractors provided transition case management for 1,723 CYSHCN, including both medical and non-medical services. This represented a 34% increase over the number reported for FY09, which may reflect increased clients seeking help and/or improved reporting. Support activities included sharing resources, updating Web pages, developing and publishing newsletter articles, and attending or presenting at state and regional conferences or trainings. 400 professionals completed the Texas Health Steps Case Management-Transition training module and 883 completed the Adolescent Health Training module. CSHCN SP staff provided subject matter expertise for annual revisions to these modules.

Activity 2: Contractors provided transition services, including distributing brochures, holding local and regional events, interacting with schools and students, case management, futures planning with parents and youth, and assistance with accessing adult health care services. CSHCN SP staff continued to serve on the Baylor College of Medicine Leadership Education in Adolescent Health (LEAH) Transition Conference Planning Committee. LEAH focused on transition with a three-pronged approach: family members attended the annual conference; residents completed a rotation in the Transition Clinic; and an Electronic Medical Record Transition Template was piloted with Texas Children's Hospital clinics.

Activity 3: CSHCN SP staff helped plan and present at the Texas Parent to Parent (TxP2P) Annual Conference which included a transition learning track and Teen Summit. The Teen Summit expanded programming from 1 to 2 days and included teens both with and without disabilities. Staff presented health care self-advocacy to young adults during a Summer Program at the Austin Resource Center for Independent Living and attended a "Destination Fair" sponsored by Central Texas area high schools.

Activity 4: The Transition Team included CSHCN SP central office and regional staff and representatives from community-based contractors. The team met bi-monthly to receive and exchange information about upcoming events and best practices. Informational program topics included Medicaid Buy-In and Infrastructure Grant initiatives, Department of Assistive and Rehabilitative Services (DARS) Rehabilitation Technology Resource Center, and the Texas Microboard Collaboration. The Team reviewed the Five-Year Needs Assessment and the FY11 Title V Grant Application. The Team recommended translating brochures into Chinese and Vietnamese contingent on funding and changing the meeting schedule from bi-monthly to quarterly.

Activity 5: CSHCN SP staff exchanged information about transition with various audiences, including email distributions to 250+ individuals statewide. Staff presented at the Texas Transition Conference; for Community Resource Coordination Groups participants; and for MCH interns.

Staff participated in the DARS Central Texas Area Transition Forum for vocational rehabilitation counselors and other agency representatives, and the Education Service Center XIII Transition Networks; attended the U.S. Department of Labor Office of Disability Employment listening session; and various relevant Webinars and calls.

Staff prepared report documents and participated in the DSHS Title V Partners activities and the Planning Group for the Five-Year Needs Assessment, which included making transition a statewide priority. A staff member was appointed to the Task Force for Children with Special Needs Transitioning Youth Subcommittee, serving as the lead for developing recommendations related to health care.

Performance Assessment: The 2005/06 NS-CSHCN indicated that 37.1% of Texas CYSHCN received services necessary to make a successful transition to adult life, falling below the national average of 41.2%. This measure was not comparable across survey years due to changes in survey questions. Transition was a priority for CSHCN SP. Themes from stakeholders informed Transition Team planning. Efforts were ongoing to improve transition case management; offer more information and training opportunities for families, case managers, and providers; collaborate with education and rehabilitation partners; and participate in state-level transition forums. DSHS benefited by partnering with the LEAH project and expected the Texas Medical Home Initiative to include CSHCN transition services in its FY11 demonstration project.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide transition case management for CSHCN through CSHCN Services Program (SP) regional staff and contractors.		X		
2. Work with selected CSHCN SP contractors and staff to provide transition services and report on best and promising practices.				X
3. Partner with youth and adults with special health care needs and their families to share information and advise the CSHCN SP about transition activities.				X
4. Lead PHSU Transition Team to coordinate CSHCN SP transition activities.				X
5. Share resources, develop trainings, and collaborate on transition planning and promising practices.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: CSHCN SP regional staff and 12 contractors provided transition case management for 4,718 CYSHCN and their families to gain access to needed medical, social, education, and other services. 114 professionals completed the Texas Health Steps Case Management Transition module.

Activity 2: With CSHCN SP funding, 47 families including 13 youth attended the 2010 Leadership Education in Adolescent Health (LEAH) annual conference. A medical home support project by People's Community Clinic included youth to develop a transition notebook for families. CSHCN SP staff helped plan the LEAH annual conference and the TxP2P Annual Conference and Teen Summit.

Activity 3: CSHCN SP staff coordinated quarterly meetings of the Transition Team to exchange ideas and provide guidance in advancing transition initiatives statewide.

Activity 4: CSHCN SP staff engaged stakeholders, made presentations, and led or participated on state-level workgroups to advance transition promising practices. CSHCN SP renewed the LEAH grant to fund families attending the annual conference, transition training for residents, and a pilot to test an electronic medical record transition template. 14 agencies statewide helped recruit conference family participants. To increase their knowledge and the potential that they will treat patients with special needs, 7 internal medicine residents completed a month-long transition clinic rotation. 13 clinics and 34 physicians enrolled in the transition template pilot.

An attachment is included in this section. IVC_NPM06_Current Activities

c. Plan for the Coming Year

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

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

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

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

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

Monitoring: Review progress and results reports.

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

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

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

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

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	80	80	80	80	81
Annual Indicator	76.7	78.2	78.6	74.4	78.2
Numerator	412110	427369	431060	412459	441810
Denominator	537301	546507	548422	554380	564742
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	80	80	80.5	80.5	81

Notes - 2010

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

Notes - 2009

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

Notes - 2008

The percent immunized are from the National Immunization Survey <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart> (accessed on 05/11/2010). Data from 2006-2009 are final.

a. Last Year's Accomplishments

Activity 1: The Texas Immunization Stakeholder Working Group (TISWG) continued to meet on a quarterly basis. At the November 2009 meeting, members received a H1N1 update, discussed

the concept of infant cocooning and improving vaccination rates for healthcare providers. At the May 2010 meeting, members discussed adult immunization issues, plans for providing system updates to ImmTrac, the state immunization registry, and the rollout of "Vaccine Choice," the automated vaccine ordering system for Texas Vaccines for Children (TVFC) providers. At the August 2010 meeting, members heard surveillance reports on the mumps outbreak (21 cases) in some Texas local jails and the 1,519 pertussis cases reported through July 2010. In addition, they learned about several projects funded through the American Recovery and Reinvestment Act of 2009 including a "cocooning" initiative to address the pertussis outbreaks and educate families on protection of newborns; an adult safety net vaccine program; and a First Responder's vaccination study. The Immunization Partnership sponsored a conference held during fall 2009 titled, "Make Your Voice Heard", which focused on raising immunization rates in the state for adults and children.

Activity 2: In FY10, 432,872 new children under 6 were entered into ImmTrac, and the current number of TVFC providers is 3,792.

Performance Assessment: While initial projections suggested that the immunization objective was reached in 2009, final numbers actually indicated a slight decrease in the number of 19-35 month olds who have received a full schedule of age appropriate immunizations. However, provisional data indicates this rate will rebound in 2010 to at or near the annual objective. Continued activities include, but are not limited to, planning ImmTrac system updates, roll-out of "Vaccine Choice," the automated vaccine ordering system for Texas Vaccines for Children (TVFC) providers, well-checks provided through Title V contractors, promoting "cocooning" to curb the state-wide pertussis outbreak, and a conference and other education and promotion opportunities to increase the immunization rate across the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.				X
2. Through provider and public training, technical assistance and education, promote the use of the state immunization registry, ImmTrac and the Vaccines for Children program.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The 51 local health department contractors with the DSHS Immunization Branch identified 94 partnerships with stakeholders, including independent school districts, Head Start programs, Immunization Coalitions, hospitals, local Red Cross organizations, fire departments, community health advisory boards, the Zapata Colonias Stakeholders Committee at the Mexican Consulate, and a local college. Activities thus far in FY11 included community planning, immunization clinics, and education/training on vaccination requirements both for children and adults, especially first responders.

Activity 2: The 51 local health department contractors with the DSHS Immunization Branch

provided training and technical assistance on the use of ImmTrac, the Texas state immunization registry, 437 times thus far in FY11; they also conducted trainings and provided technical assistance on the Vaccines for Children program 672 times.

An attachment is included in this section. IVC_NPM07_Current Activities

c. Plan for the Coming Year

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

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

Monitoring: Track the number and type of partnership activities.

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

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	37	37	32	32	32
Annual Indicator	33.7	34.9	34.9	33.1	35.1
Numerator	17918	18449	18934	17907	18225
Denominator	531239	528403	542343	540995	519372
Data Source			Nativity Data and Office of State Demographer	Nativity Data and Office of State Demographer	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
	2011	2012	2013	2014	2015
Annual Performance Objective	34	34	34	33.5	33.5

Notes - 2010

Natality data reported for 2010 is estimated. Estimates are linear projections of based on data from 1991 through 2008.

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

Notes - 2009

2009 natality data is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Denominator data provided by the Office of the State Demographer.

Notes - 2008

2008 Natality data is final. This indicator has been adjusted for final data.

Denominator data provided by the Office of the State Demographer.

a. Last Year's Accomplishments

Activity 1: DSHS served 13,184 teens through 78 Title V, X, and XX family planning contractors in FY10. The Education Service Centers reached 51,664 professionals and community members through workshops, site visits, coalition activities, conferences, distance learning activities, and through mass communication about teen pregnancy prevention. DSHS, the Office of the Attorney General, and the Texas Education Agency (TEA) submitted an application for the "Support for Pregnant and Parenting Teens and Women" funding announcement in summer 2010. DSHS also submitted an application for the Teen Pregnancy Prevention funds made available by the U.S. Department of Health and Human Services (HHS) Office of Adolescent Health, and for the community-based abstinence education funds through the HHS Administration for Children and Families.

Activity 2: 3 presentations on teen birth data and legal and programmatic implications were made at 2 conferences in October 2009, the Texas Association Concerned with School-Aged Parenthood and the Texas Department of Family and Protective Services (DFPS) Partners in Prevention annual conferences. DSHS and TEA received a National Stakeholders Collaboration project to address adolescent reproductive and sexual health disparities. A strategic plan was developed to address these disparities through a positive youth development (PYD) framework. The plan includes developing joint messages across program areas to educate, involve, and mobilize key stakeholders.

Activity 3: 49 focus groups were conducted and data were analyzed for the Texas Teen Opportunity Project (T-TOP). The focus groups identified motivations for and against early child-bearing among parenting/non-parenting teens, young adults, and parents of teens. A final report was submitted to DSHS in August 2010. The findings addressed issues of youth development, parent-child communication about sex and contraception, and sexual relationships. The T-TOP findings reflect differences in norms by sex and, to a lesser degree, by racial/ethnic groups including expectations of work roles by age 25 for parents of teens. Communication messages were shown to differ somewhat by sex; less-aculturated Latino parents were shown to want help talking to their teens about sex; young men more often expressed a desire for experiencing pleasure as a barrier to using condoms; young women, especially young Latinas, more commonly said that it is young women's responsibility to prevent pregnancy; and poor relationship quality

among youth interferes with contraceptive use.

Activity 4: DSHS regional staff engaged in community-and population-based activities, including work with School Health Advisory Committees, school districts, teen pregnancy prevention coalitions, and other family/youth/health partnerships, to provide data and information on evidence-based teen pregnancy prevention programs. Regional staff also provided health information for teens through schools, presentations, health fairs, and referrals for health care services. Approximately 2,800 young people were served through these activities. DSHS Abstinence Education Program (AEP) and the Healthy Futures Alliance in San Antonio worked collaboratively to create and strengthen partnerships between schools and community organizations with the goal of preventing teen pregnancy and STIs locally. In FY10, AEP provided technical assistance to coalitions in El Paso and Hidalgo counties. Each coalition met four times, including a community-wide strategic planning session.

Activity 5: The Texas Healthy Adolescent Initiative awarded 6 contracts in January 2010. The sites focused on establishing Local Community Leadership Groups (LCLGs), conducting a community needs assessment, and initial development of a community strategic plan. The LCLGs are comprised of 15 areas of expertise that impact the lives of young people, including the business community, faith-based organizations, sports and recreation, schools, etc. Findings from the needs assessments show that youth generally have poor perceptions of themselves and adults have negative perceptions of young people in their communities. The sites set goals to increase youth-adult partnerships and awareness of PYD strategies, and improve adult perceptions/interactions with young people.

Performance Assessment: Since 2005, adolescent birth rates have remained stable, but a rising teen population impacts these rates. Integrating PYD efforts will help decrease these rates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase opportunities to engage in teen pregnancy prevention activities at the state and local levels.				X
2. Coordinate educational and awareness activities to increase understanding of teen pregnancy prevention, including disparities (racial/ethnic, geographic) in rates.			X	
3. Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent adolescent pregnancy.				X
4. Coordinate and implement regional teen pregnancy prevention activities.			X	
5. Implement Texas Healthy Adolescent Initiative in local communities.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: DSHS received funding for the Abstinence Education Program (AEP) from the Administration for Children and Families (ACF). DSHS submitted the state abstinence plan and released a Request for Proposals for the AEP. DSHS Family Planning Program served 5,789 youth = 17 through 73 Title V, X, and XX contractors.

Activity 2: Over 7,100 professionals, community members, and parents received information on the prevention of sexual risk taking behaviors and teen pregnancy prevention from the school health specialists. six presentations on the Texas Teen Opportunity Project (T-TOP) were made at three conferences. Local coalitions in El Paso and Hidalgo counties continue strategic planning to address teen pregnancy. DSHS and the Texas Education Agency published the 2009 Texas Youth Risk Behavior Survey Summary databook.

Activity 3: Power2Wait toolkits were distributed to school districts and community organizations, and 16 Youth Leadership Clubs were created.

Activity 4: DSHS regional staff attended over 150 events to share teen pregnancy data or participate in activities with schools, advisory councils, teen pregnancy prevention coalitions, and other partners.

Activity 5: Six contractors received training and technical assistance from DSHS and federal partners. Contractors have started implementing strategic plans, focused on training community members and creating youth-friendly and focused communities.

An attachment is included in this section. IVC_NPM08_Current Activities

c. Plan for the Coming Year

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

Output Measure(s): Number, type, and format of activities implemented, including National Stakeholders Collaborative and YRBS fact sheets; number and type of activities coordinated by or implemented by Health Service Region Staff; number of teen pregnancy prevention activities provided through the Education Service Centers.

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

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

Output Measure(s): Number of meetings and types of partners engaged; developed proposals for implementation; implemented activities; number of Power2Wait toolkits distributed; number of Youth Leadership Clubs; number of Title V, X, and XX contractors; number of teens (age 17 and under) receiving family planning services.

Monitoring: Review meeting notes; quarterly progress reports.

Activity 3: Implement Texas Healthy Adolescent Initiative in local communities.

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	35	35	34.4	37	37
Annual Indicator	22.7	22.7	34.4	34.4	34.4
Numerator	71225	72898	122241	126694	128530
Denominator	313768	321135	355351	368296	373633
Data Source			Texas Education Agency	Texas Education Agency	Texas Education Agency
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance Objective	37	37	39	39	39

Notes - 2010

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

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

Notes - 2009

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

Notes - 2008

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 2008 (Source: Texas Education Agency; <http://www.tea.state.tx.us/student.assessment/reporting/>).

a. Last Year's Accomplishments

Activity 1: During FY10, the DSHS Oral Health Program (OHP) regional dental teams provided preventive dental services to 11,789 children including third graders. Preventive dental services include dental sealants when determined to be medically necessary and beneficial for the child. Of the 11,789 children, 4,159 received dental sealants on 18,419 teeth.

Activity 2: DSHS OHP continues to use the results of the 2007 Basic Screening Survey, which is a statistical sampling of third graders in Texas, to monitor the level of untreated dental caries. Of 2,583 non-Medicaid third graders, 45% were found to have untreated caries and 72% had untreated and/or treated caries (decay experience). Therefore, OHP regional dental teams continue to provide preventive dental services to low-income children in an effort to decrease the level of untreated decay and decay experience.

Activity 3: For FY10, the DSHS OHP regional dental teams collaborated with approximately 200 public elementary schools and Head Start programs and 25 stakeholders including dental professional groups, dental schools, dental hygiene academic programs, and local health departments in rural and underserved areas of the state providing free preventive dental services to low-income children.

Performance Assessment: While the number of 3rd grade children receiving a protective sealant on at least one permanent molar appears to be growing in proportion to the number of 3rd graders in Texas, analysis of BSS data indicated that continued efforts towards preventive dental services for non-Medicaid children are necessary. This is evidenced by a higher percentage of low-income, non-Medicaid 3rd grade children who have fewer dental sealants, higher levels of untreated decay, and a lower percentage self-reporting that they have had a dental visit within the previous 12 months. Staff are continuing to collaborate with public elementary schools, Head Start programs, dental professionals, and local health departments in rural and underserved areas of the state to promote dental sealant use. It is anticipated that Texas will conduct the next Basic Screening Survey in the 2011-2012 school year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue providing dental sealants to Texas third grade population statewide.	X			
2. Continue to monitor data on the numbers of third graders with untreated caries to use in guiding programmatic decisions.				X
3. Collaborate with multiple stakeholders to develop activities and materials to promote the use of dental sealants to both providers and recipients of services.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The DSHS Oral Health Program (OHP) has provided dental sealants to 2,629 children through school-based dental sealant efforts and/or through collaborations with academic, community, and faith-based organizations. This represents 32.1% of the 8,190 of children screened during the first half of FY11.

Activity 2: Of 8,190 children screened, 531 (6.4%) were identified as needing early care (within a few weeks) and 2,164 (26.4%) were identified as needing urgent emergency care (within 24 hours). The data collected is convenience data and is not representative of the state. It shows oral health improvement when compared to recent statewide Basic Screening Survey data.

Activity 3: School-based and Head Start clinics provided screenings for 8,190 children. DSHS OHP offered these services through programs and collaborations with academic, community, and faith-based organizations.

Activity 4: The dental director, HHSC, and Texas Health Steps (THS) reviewed provider training modules. Posters are currently in development that support provider understanding and implementation of the First Dental Home and Oral Evaluation and Fluoride Varnish (OEFV) in the

Medical Home initiatives. Distribution will be to THS providers and other community-based partners. DSHS regional staff promoted online trainings on the First Dental Home, OEFV, Oral Health Examinations By Dental Professionals, and Oral Health for Primary Care Providers. **An attachment is included in this section. IVC_NPM09_Current Activities**

c. Plan for the Coming Year

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

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

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

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

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

Monitoring: Analyze, interpret and report on data collected.

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

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

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

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

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	5.4	5.1	4.7	4.7	4.6
Annual Indicator	4.9	4.9	3.5	3.7	4.1
Numerator	260	261	188	200	210
Denominator	5287340	5332129	5384151	5449069	5117214
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
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
	2011	2012	2013	2014	2015
Annual Performance Objective	4	3.8	3.6	3.5	3.4

Notes - 2010

Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 1999 through 2008.

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

Notes - 2009

Mortality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Denominator data provided by the Office of the State Demographer.

Notes - 2008

2008 Mortality data is final. This indicator has been adjusted for final data.

Denominator data provided by the Office of the State Demographer.

a. Last Year's Accomplishments

Activity 1: In FY10, 332 organizations participated in car seat distribution classes. 1,653 car safety seat classes were held in various communities across Texas and 5,892 safety seats were distributed to low-income families at the conclusion of the educational classes.

Activity 2: Nine Child Passenger Safety (CPS) technician courses were held throughout FY10. Five CPS Technician Workshops sponsored by Safe Riders provided training to 72 students in Harlingen, Mt. Pleasant, Stephenville, Lubbock, and Tomball. Safe Riders assisted with an additional four CPS Technician workshops and trained 71 students in Fort Worth, Houston, and Kyle. Four Safe Riders Technician Renewal Classes and one teleconference course were held with 140 students participating.

Activity 3: Forty-five child seat checkups and inspection stations were held statewide including locations in Austin, Beaumont, Harlingen, Laredo, Lubbock, and several other communities. There were 1, 619 families who received education about child safety seats, booster seats, and safety seat laws and had their child safety seat restraints checked by CPS technicians. Thirty-seven Child Passenger Safety and Safety Belt presentations were conducted at elementary

schools, medical centers, mom and baby expo, county sheriff's office, and for the Department of Family and Protective Services. These presentations educated 916 individuals, and three presentations were made for television audiences through local news shows.

Activity 4: The State Child Fatality Review Team Committee (SCFRT) continued to support recommendations that will reduce the risk of motor vehicle crash deaths. In addition to not using wireless devices while driving, the SCFRT is researching a recommendation to repeal the Texas statute that allows for parent-taught driver's education. Research conducted by the National Highway Traffic Safety Administration (NHTSA) shows that teen drivers who are parent-taught are at much greater risk of motor vehicle crashes resulting in injury and in death. The SCFRT is also examining hyperthermia deaths of infants and toddlers left in cars that become overheated, as Texas leads the nation in these types of preventable deaths. The South Plains CFRT hosted a one-day workshop on CFR, injuries, and deaths of children in their 22-county area, and the 120 attendees were trained by a Department of Public Safety Officer on child passenger safety seat installation. Several local teams have sponsored and participated in child passenger safety seat clinics.

Activity 5: During FY10, DSHS regional staff participated in over 80 events to provide safety seat checks and distribute approximately 500 child safety car seats and booster seats. Additional activities conducted related to motor vehicle and bike safety included distributing calendars with Child Passenger Safety information; working with School Health Advisory Committees (SHACs) and school districts to implement driver safety programs, such as Teens in the Driver Seat; providing information related to all-terrain vehicle child safety, and disseminating information on child passenger safety and bike safety to child care centers, summer camps, WIC clinics, and other community-based settings.

Performance Assessment: Adjustments to population estimates were made and 2008 data were finalized causing significant change in rates from data reported in previous years. These rates are significantly lower than annual objectives, and are consistent with the national rates reported for Healthy People 2010. As a result of increased collaboration between the SCFRT, local CFRTs, and the Texas Department of Transportation, and continued education, awareness and distribution of child safety seats, it is anticipated that the rates will remain fairly stable with continued awareness and prevention activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute child safety seats to low-income families via educational classes throughout the state.		X		
2. Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.			X	
3. Conduct traffic safety presentations throughout the state.			X	
4. Review of report on child deaths resulting from motor vehicle crashes and develop policy recommendations and activities aimed at reducing such deaths.				X
5. Conduct regional safety seat check activities throughout the public health regions.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Subgrantees were provided 3,177 child safety seats. Program partners provided 876 child safety seat classes that distributed 2,980 child safety seats.

Activity 2: Safe Riders CPS Technician Workshops were held in 5 cities and trained 55 students.

Activity 3: The Safe Riders Program conducted 29 presentations in four cities at schools, community organizations, child care facilities, and workforce development fairs and provided traffic safety information to 845 participants, including parents, students, teen parents, and child care staff.

Activity 4: Local CFRT reviewed 211 motor vehicle crash deaths from 2008, which were analyzed in the 2010 Annual Report. Activities included car passenger safety seat and bicycle helmet distribution, seat belt education, and presentations on the dangers of texting and driving and leaving children in cars. The State CFRT Committee recommendations included: banning use of wireless devices while driving; repeal allowing parent-taught driver education; requiring parents of teens to appear in court for moving violations; and creating a statewide campaign about dangers in and around cars.

Activity 5: DSHS regional staff participated in approximately 100 activities, including health fairs, car seat safety checks and distribution, and other activities through injury prevention coalitions, schools, and CFRTs. One coalition received a grant for pedestrian safety education. Over 350 car seats were checked or installed and distributed.

An attachment is included in this section. IVC_NPM10_Current Activities

c. Plan for the Coming Year

Activity 1: Distribute child safety seats to low-income families via educational classes throughout the state.

Output Measure(s): Number of organizations that participate in the distribution and education program; the number of safety seats issued to participating organizations; and the number of safety seats distributed.

Monitoring: Maintain a current list of participating organizations; track the number of seats distributed to the organizations on an ongoing basis.

Activity 2: Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.

Output Measure(s): Number of CPS technician training courses per quarter; number of students per course; number of update/renewal classes for certified CPS technicians; number of students per update/renewal classes.

Monitoring: Track number of technician training courses (per calendar year); number of students per course; number of update/renewal classes per year; number of students per class.

Activity 3: Conduct traffic safety presentations throughout the state and health service regions.

Output Measure(s): Number of traffic safety presentations conducted; number of persons attending each presentation; number of child safety seat check activities; number of safety seat checks conducted/number of safety seats installed; number of motor vehicle safety activities.

Monitoring: Track progress of presentations conducted (per calendar year); quarterly progress reports from regional staff.

Activity 4: Review of report on child deaths resulting from motor vehicle crashes and develop

policy recommendations and activities aimed at reducing such deaths.

Output Measure(s): Annual Child Fatality Review Team Report on child deaths that includes motor vehicle crash deaths and policy recommendations; CFRT involvement in motor vehicle safety awareness activities; training session(s) on reducing motor vehicle crash deaths and appropriate prevention strategies at CFRT Annual Conference.

Monitoring: Updates on child deaths, prevention and training activities, and potential recommendations at quarterly State Child Fatality Review Team Committee meetings.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	38	38.5	37	48.5	56
Annual Indicator	34.9	46.1	46.9	48.5	50.2
Numerator		182673	189896	194919	208185
Denominator		396167	405242	401610	414640
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	51	51.5	52	52.5	53

Notes - 2010

For 2008, 2009, and 2010, estimates are linear projections using data from the National Immunization Survey for 2002 through 2007. Denominator data are all live births. The estimate for 2010 is based on a linear projection using natality data from 2002 through 2008. Numerator data are calculated by multiplying the percent from the National Immunization Survey and the total number of live births.

Notes - 2009

For 2008, 2009, and 2010, estimates are linear projections using data from the National Immunization Survey for 2002 through 2007. Denominator data are all live births and are

provisional for 2009. Numerator data are calculated by multiplying the percent from the National Immunization Survey and the total number of live births.

Notes - 2008

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. Natality data is final for 2008. Numerator data are calculated by multiplying the percent from the National Immunization Survey and the total number of live births. This indicator has been adjusted for final data.

a. Last Year's Accomplishments

Activity 1: WIC breastfeeding trainers completed a train-the-trainer course with 23 peer counselors (PCs) and 29 PC Trainers. New breastfeeding materials were produced. DSHS staff participated in state and national breastfeeding coalition meetings/phone conferences. The Texas Hospital Association's annual hospital survey added a question regarding the number of lactation consultant FTEs. Information was shared via state and national conferences, professional meetings, webinars, DSHS leadership meetings, a newsletter article, and requests from external partners. There were 47,920 hits to the DSHS breastfeeding webpage. The DSHS Infant Feeding Workgroup (IFW) met 6 times and 2 (WIC and IFW) breastfeeding strategic planning processes were initiated. DSHS sponsored a Texas Breastfeeding Coalition strategic planning meeting and executed 1 Baby Café contract. WIC initiated new food packages, including an enhanced breastfeeding package. Texas WIC received an award for most improved breastfeeding rates in FY09. A statewide breastfeeding multi-media campaign was implemented. Provisional data from the National Immunization Survey (NIS), released in August 2010, indicate that, of Texas infants born in 2007, 75.8% were ever breastfed, 43.6% were breastfed at 6 months, and 21.8% were breastfed at 12 months. Exclusive breastfeeding rates through 3 and 6 months were 27.6% and 11.1%. The August 2010 WIC breastfeeding initiation rate was 76.8%.

Activity 2: Texas Ten Steps (TTS) implemented new criteria. 19 of the 75 hospitals designated prior to the reapplication process did not reapply and 4 new hospitals were designated for a total of 60 TTS hospitals. 5 birthing facilities participated in the Baby Friendly Hospital Initiative (BFHI) and 8 submitted letters of intent. Outreach included reports, materials, presentations, and training for 2,604 health professionals. NIS 2007 birth cohort data indicate that 34.6% of Texas breastfed infants received formula in the first 2 days of life. Newborn screening demographic information indicate that 77% of Texas infants were breastfed, 41.6% were exclusively breastfed, and 46.0% of breastfed infants received formula on the 2nd day of life. 2009 WIC IFPS data indicate that <50% reported their babies experienced evidence-based care practices such as breastfeeding in the first hour after birth (37.6%), receiving breast milk at the first feeding (45.9%), exclusive breastfeeding during the hospital stay (22.4%), and avoiding pacifiers (26.8%). Though most respondents reported that they were told how to recognize when their baby is hungry (77.2%) and were encouraged to breastfeed whenever their baby wanted (61.1%), 57.9% reported that they were told to limit the length of time their baby spends breastfeeding. Free formula samples were given to 83.6% of respondents. Women who reported they were given instruction to breastfeed whenever their baby wanted and women reporting that their infants were exclusively breastfed at the hospital were more likely to report breastfeeding for as long as they wanted.

Activity 3: Progress includes 34 new inquiries, 28 applications, and 22 worksites designated as Mother Friendly Worksites (MFW) in FY10; MFW Program presentations given at a state wellness conference and the Texas Breastfeeding Coalition; MFW rules revision process initiated, and a \$2.8 million competitive grant awarded for MFW Policy Initiative. 2009 WIC IFPS workplace experiences data indicate the rate of breastfeeding initiation among women who returned to work postpartum was 71.5%, compared to 73.4% of the total surveyed population. Return to work or school was the leading response reported for the main reason women did not breastfeed (33.0%) and the main reason women began use of formula (27.3%). Of women who returned to work postpartum, 56.2% reported they did not breastfeed for as long as they wanted. Women who returned to work postpartum for 10 or more hours per week were less likely than those who

returned to work for fewer hours to report that they breastfeed for as long as they wanted.

Performance Assessment: Provisional data indicate the 6-month breastfeeding rate continues to exceed 40% and meets the HP2010 objective of 50%, although the TX 2010 objective was not met. New data sets and cross-program collaboration enhanced planning. Activities promoting policy and environmental changes in health care, worksites, and communities support breastfeeding initiation, continuation, and exclusivity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve promotion and support of breastfeeding in the community.			X	X
2. Improve promotion and support for breastfeeding in the health care system.			X	X
3. Improve promotion and support of breastfeeding in the workforce.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Community supports included 78 breastfeeding materials produced; 2967 website hits; coordination/participation in collaborative and coalition meetings and state-to-state technical assistance and contractor calls; response to constituent calls; 28 new peer counselor trainers trained; professional presentations given; 3 communities funded for mother-to-mother drop-in centers; and 2 new lactation resource/training centers opened.

Activity 2: There are 63 Texas Ten Step hospitals, 6 Baby-Friendly Hospitals (BFH), and 16 hospitals that have registered intention to seek BFH status. Outreach included 80 health care professional training sessions provided; 20 materials developed; new website launched; FY11 outreach timeline developed.

Activity 3: Activities included 26 new Mother-Friendly Worksites (MFW) designated; 9 new partnerships developed; 12 professional presentations given; 25 new tools developed; 12 trainings and webinars held; technical assistance provided to 18 public agencies; outreach to 25 state agencies, local health departments, and public hospitals; 4 contracts executed; 8 contracts drafted; formative assessment began; new website launched; MW rule revisions proposed.

Activity 4: Activities included 4 infant feeding workgroup meetings, HHS-enterprise MFW policy drafted; technical assistance for breastfeeding coalition capacity development provided; 3 new breastfeeding coalitions developed; and plans for maternity services and worksite outreach developed.

An attachment is included in this section. IVC_NPM11_Current Activities

c. Plan for the Coming Year

Activity 1: Develop promotion and support of breastfeeding in the community.

Output Measure(s): Completed community support report including indicators related to

breastfeeding rates; information, communication, referrals, and outreach activities; mother-to-mother support; professional support; and infrastructure building activities.

Monitoring: Review progress toward completion of report.

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

Output Measure(s): Completed health services report including indicators related to birth facility support and information, education, and communication for health services.

Monitoring: Review progress toward completion of report.

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

Output Measure(s): Completed workplace report including indicators related to increasing support for breastfeeding in the workplace through population based activities and infrastructure building activities.

Monitoring: Review progress toward completion of report.

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

Output Measure(s): Number and types of activities implemented within DSHS from the DSHS Infant Feeding Strategic Plan.

Monitoring: Document progress toward implementation of strategic plan.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	90	92	96	94	94
Annual Indicator	91.0	92.5	93.1	95.4	88.2
Numerator	366442	379007	383596	389612	376311
Denominator	402711	409639	412099	408391	426415
Data Source			Newborn Screening Database and Natality Data	Newborn Screening Database and Natality Data	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
	2011	2012	2013	2014	2015
Annual Performance Objective	94	94.5	95	95.5	96

Notes - 2010

Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence. Final natality data are available for 2008 only. In 2010, denominator data are estimated using a linear projection using natality data from 1996 through 2008.

Notes - 2009

Numerator data are final. Denominator data is provisional. This indicator has been adjusted for provisional data. In the previous grant application, the denominator was based on a linear trend. Denominator includes all births in Texas regardless of maternal state of residence.

Notes - 2008

Numerator and denominator data are final. This indicator has been adjusted for final data. Denominator includes all births in Texas regardless of maternal state of residence.

a. Last Year's Accomplishments

Activity 1: DSHS monitored 250 facilities in FY10 for adherence to the newborn hearing screening mandate; 158 were compliant and 92 were noncompliant. DSHS had two certification periods in FY10. In October 2009, 55 birthing facilities were certified with the following ratings: 11 Distinguished (three years until the next review), 21 Standard (one year until the next review), 8 Provisional (6 months until the next review), and 15 Preliminary (initial certification process). In June 2010, 38 facilities were certified with the following ratings: 1 Distinguished, 23 Standard, 12 Provisional, and 2 Preliminary.

Activity 2: In FY10, 381,211 newborns required a hearing screen at birth within DSHS certified birth facilities. Newborns that do not require a newborn hearing screen include but are not limited to, newborns that were too ill to screen, parents who refuse the screen, and/or newborns that passed away. Of the newborns needing a hearing screen at birth, 376,784 (99%) were screened prior to hospital discharge. Of those who received a birth screen, 367,964 newborns (98 %) passed and 8,820 (2%) did not pass. A total of 12,046 newborns required follow-up care, which includes the 3,226 (27%) that missed the screening and the 8,820 (73%) who did not pass the birth screen.

Activity 3: The Texas Early Hearing Detection and Intervention (TEHDI) program is in the process of developing a comprehensive training curriculum. The curriculum will have 8 modules for each of the major stakeholders within the early hearing detection and intervention process, including TEHDI Overview; Prenatal; Universal Newborn Hearing Screening (UNHS); Outpatient Hearing Screening; Audiology; Ear, Nose and Throat; Medical Home; and Early Intervention.

During FY10, the program created a brand and logo to establish a recognizable, cohesive, and unique image for the program. The program consulted with stakeholder groups to complete 4 of the modules, including TEHDI Overview, Prenatal, UNHS, and Medical Home. The additional modules, Outpatient Hearing Screening, Audiology, Ear, Nose, and Throat, and Early Intervention, are in development.

The program distributed a total of 289,642 materials during FY10. Materials distributed include 2,015 of 1-3-6 Guide; 1,183 of FAQ Sheet for Providers; 6,112 of Information for Health Professionals; 271,695 of Sounds of Texas (Eng/Sp); 8,475 of Sounds of Texas (Eng/Vtmse); 91 of Audiology Desk Tool; 52 of Just in Time Guide: Audiologists; and 19 of Just in Time Guide: Primary Care Providers.

The TEHDI program exhibited at 12 conferences with an estimated 8,000 participants including, but not limited to, National EHDI Conference in Chicago, the Texas Speech and Hearing Association Convention in Fort Worth, and Statewide Conference on Education for the Deaf and Hard of Hearing in Fort Worth. The program provided trainings to stakeholders specifically, 5 overview trainings, 5 trainings to Hearing Loss Resource Specialists, 4 Prenatal trainings, and 2 trainings to audiologists.

Activity 4: The TEHDI program and its collaborators performed 41 trainings for hospital and medical home providers, specifically 36 onsite TEHDI database trainings to hospital staff, 4 UNHS presentations to hospital staff, and 4 Medical Home trainings. The TEHDI program has an online module on Newborn Hearing Screening which is housed on the DSHS Texas Health Steps website. During FY10, 343 healthcare providers (90 doctors; 30 physician assistants; 171 nurses; 2 speech, language, and hearing providers; 10 social service providers; and 40 others) took the online module. Licensed professionals that completed the module received free continuing education units.

A web-based reporting component in the TEHDI system, Provider Access Tool (PAT), is available for Primary Care Providers (PCPs) to access hearing screening results and track follow-up care of newborns with suspected hearing loss. The TEHDI program performed a comprehensive outreach campaign including monthly postcards alerting PCPs of newborns that have been referred to their practice. At the end of FY10, 246 PCPs have requested access to PAT.

Performance Assessment: Data reported above is based on the definition in the Block Grant Guidance that uses "all births" as the denominator. DSHS program data based on "live births" indicate continued progress from 92% in 2009 to 99% in 2010. Outreach, technical assistance, and a provider web-based system continue to improve screening and follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria.				X
2. Evaluation of the TEHDI program utilizing system data to manage the program.		X		X
3. Collaborate with multiple stakeholders to develop and disseminate educational materials for providers and parents.			X	
4. Provide training, outreach and technical assistance to hospitals and medical home providers.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The Newborn Screening (NBS) program certified 130 birthing facilities and 248 birthing facilities were monitored for adherence to the NBS mandate in the first half of FY11. 86 facilities were noncompliant, and 162 facilities were in compliance.

Activity 2: There were 189,657 infants born in TEHDI-reporting birthing facilities. Of these, 187,831 (99%) received a hearing screen before hospital discharge. Of those screened, 183,055 (97%) passed the screening. A total of 5,919 (3%) required follow-up upon discharge, including

1,143 who missed the birth screen, and 4,776 who did not pass the birth screen.

Activity 3: A program brand and logo was created. Three modules of an 8-module training curriculum were developed. Program materials were updated or newly produced for a total of 16 printed resources. 179,297 materials were distributed to stakeholders. Exhibits were held at 4 conferences with a total of 1,270 attendees. 20 stakeholder meetings were conducted.

Activity 4: Activities included 12 trainings and 4 continuing education (CE) modules presented onsite to hospital staff; 16 CE Medical Home presentations; 129 professionals received CE through the online Texas Health Steps Newborn Hearing Screening module. 382 medical home providers (141 new users) received outreach through the Provider Access campaign, which includes an online module and monthly postcard notifications.

An attachment is included in this section. IVC_NPM12_Current Activities

c. Plan for the Coming Year

Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria.

Output Measure(s): Number of compliant and noncompliant programs that report newborn hearing data to DSHS.

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

Activity 2: Evaluation of the TEHDI program utilizing system data to manage the program.

Output Measure(s): Number and percent of infants screened before 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: Collaborate with multiple stakeholders to develop and disseminate educational materials for providers and parents.

Output Measure(s): Number and type of stakeholders involved in activities, type and number of materials developed and disseminated, number of stakeholder meetings held.

Monitoring: Documentation of meetings held and number of educational materials distributed; Review THSteps CE module completion records.

Activity 4: Provide training, outreach, and technical assistance to hospitals and medical home 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.

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	2006	2007	2008	2009	2010
Annual Performance Objective	20	19.9	20	20	19.5
Annual Indicator	18.9	21.4	17.9	16.5	17.7
Numerator	1224279	1434980	1216968	1149840	1245777
Denominator	6476859	6720386	6783441	6966193	7034956
Data Source			US Census Bureau, Current Population Survey	US Census Bureau, Current Population Survey	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
	2011	2012	2013	2014	2015
Annual Performance Objective	17	17	17	16.5	16

Notes - 2010

Numerator and denominator data for FY2010 are linear projections based on data from 2003 through 2009 from the US Census Bureau, Current Population Survey, Annual Social and Economic Supplement (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

Notes - 2009

Data presented in the columns from 2006 through 2009 are correct and final. This indicator has been adjusted for final data. Numerator and denominator data are provided by the US Census Bureau, Current Population Survey, Annual Social and Economic Supplement (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

Notes - 2008

Data presented in the columns from 2006 through 2009 are correct and final. Numerator and denominator data are provided by the US Census Bureau, Current Population Survey, Annual Social and Economic Supplement (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

a. Last Year's Accomplishments

Activity 1: According to estimates provided through the US Census Bureau's 2009 American Community Survey, there were currently approximately 6,966,193 children under the age of 18 residing in Texas. Of these children, approximately 1,149,840 (16.5%) do not have health insurance coverage.

Activity 2: Title V-funded prenatal care and health and dental services for children and

adolescents continued to be provided through fee-for-service contractors who are required to screen and refer all clients for Medicaid and CHIP. In FY10, Title V Maternal and Child Health data showed 5,283 children were enrolled into the CHIP perinatal benefit plan and 14,037 children were enrolled in CHIP. In FY10, there were 30,241 individuals under the age of 21 served by Title V-funded contractors throughout the state.

Performance Assessment: According to the Census, Texas ranks second in the percent of children under 18 without health insurance. The number of uninsured children is estimated to increase from 2009 to 2010 while the number of youth under 21 served by Title V-funded prenatal care and child health and dental services decreased from 35,459 in 2009 to 30,241 in 2010. Increased outreach and education efforts have been implemented to help ensure that available public assistance programs (Medicaid and CHIP) are maximized by insuring as many eligible children as possible. These efforts will continue and Title V staff will continue to seek opportunities to support these efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and report the percentage of children without health insurance.				X
2. Screen all children at Title V-funded clinics for potential CHIP (including the new CHIP perinatal benefit) and Medicaid eligibility and make referrals to appropriate programs.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Estimates are developed from various sources for calendar years. There are no updates for this activity until the end of FY11.

Activity 2: As of May 20, 2011, there were 17,880 individuals under the age of 21 served by Title V-funded contractors throughout the state. Of that group, 1,815 were served by CHIP Perinatal, 8,023 were served by Title V Child Health providers and 8,042 were served by Title V Dental providers.

Activity 3: DSHS regional staff worked with DSHS Specialized Health Services staff to coordinate activities related to children's access to insurance through participation in health fairs and referrals for children attending DSHS clinics. Over 1,800 referrals to CHIP and over 2,300 referrals were made were made to children's Medicaid services.

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 Service Region reports.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	23	22	21	23	29
Annual Indicator	23.9	24.1	31.5	31.4	31.3
Numerator	160793	164231	146631	140676	142942
Denominator	671445	680571	465319	448039	456124
Data Source			WIC Program Data	WIC Program Data	WIC Program Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance Objective	31	30.9	30.8	30.7	30.6

Notes - 2010

Data for 2005, 2006 and 2007 are for children ages one to five years of age. This was due to an error in the code used to create the tables. Data for 2008, 2009, and 2010 are correct. The targets for 2008, 2009, and 2010 are not reflective of this error.

Denominator data are all children ages two to five years of age. These data are reported through certification data provided by the WIC program. Numerator data are all children with a BMI at or

above the 85th percentile as noted in the Health and Nutrition Risk Tables provided by the WIC program.

Notes - 2009

Data for 2005, 2006 and 2007 are for children ages one to five years of age. This was due to an error in the code used to create the tables. Data for 2008, 2009, and 2010 are correct. The targets for 2008, 2009, and 2010 are not reflective of this error.

This indicator has been adjusted for final data. Denominator data are all children ages two to five years of age. These data are reported through certification data provided by the WIC program. Numerator data are all children with a BMI at or above the 85th percentile as noted in the Health and Nutrition Risk Tables provided by the WIC program.

Notes - 2008

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 FY10, 464,366 of the 492,753 women participating in WIC received nutrition education (94.2%), and 1,548,963 of the 1,677,199 total WIC population (women and children) received nutrition education (92.4%). \$453,000 was dispersed to 31 WIC local agencies as FY10 Obesity Prevention Mini Grants for special education initiatives that target obesity in the WIC population. A total of \$1,184,870 has been paid to 63 WIC local agencies to contract for registered dietician (RD) services or to defray staff RD salaries. WIC program data indicate that, of infants born to mothers enrolled in WIC at the time of delivery ("born-to-WIC"), 73.4% initiated breastfeeding in the hospital.

Activity 2: WIC Wellness Works (WWW) is a staff-centered wellness program that encourages WIC staff to eat better and exercise more. Results from the FY10 WWW pre survey suggest that: the majority of new staff participants are female (97%) as well as Hispanic/Mexican American (55%), more than two-thirds have a college or graduate degree, and more than three-fourths of respondents reported spending at least 25% of their job time counseling or teaching WIC participants. Average self-reported Body Mass Index (BMI) for females was 30.2 (a BMI > 30 is considered obese) and 26.3 for males (a BMI of 25-29 is considered overweight). Data for the 2009 WIC Infant Feeding Practices Survey were analyzed, with 5,427 surveys completed by biological mothers enrolled in WIC during pregnancy. A state, regional, and WIC Local Agency report was distributed in May 2010. Local WIC staff use this report to complete the Breastfeeding Promotion Plan. The survey is administered every 2 years. Additional data will be available in FY11 from a follow-up survey focused on post-implementation attitudes and behavior changes resulting from the new WIC food package implemented in FY09.

Performance Assessment: The number of children with a BMI at or above the 85th percentile who receive WIC services has remained steady from 2008-2010. Efforts have been made at the state and local level to address childhood obesity, some of which include: implementation of local obesity prevention activities via mini-grants, breastfeeding media efforts, and WIC food package changes. Exploring further opportunities for education and prevention activities and a continued and expanded focus on breastfeeding throughout DSHS may contribute to future reductions in childhood obesity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.			X	
2. Study food consumption patterns in WIC families.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: In the first half of FY11, 321,723 of the 384,412 WIC enrolled women (83.7%) received nutrition education and 1,094,131 (78.7%) of the 1,390,279 total WIC population (women and children) enrolled received nutrition education.

38 local WIC agencies were allocated \$445,000 as Obesity Prevention Mini Grants (OPMG) to plan, implement, and evaluate their projects. Funds were used for prevention initiatives such as healthy cooking demonstrations, establishing community gardens, promoting physical activity by establishing walking groups, health fairs and carnivals, and conducting supermarket tours.

Over 66% of the target audience for the OPMG projects focused on WIC families. Over 28% also incorporated activities for WIC staff.

64 WIC agencies received a total of \$1,895,240 to fund salaries of contracted Registered Dietitians (RDs) or to defray the cost of staff dietitians.

Activity 2: Staff completed the remaining three research question reports on the Texas Food and Nutrition Survey for pre-rollout results, and prepared summaries for all 10 questions; completed collection of almost 7,000 post-rollout surveys, cleaned the post-rollout data, and prepared reports for Texas WIC. Planning for the next wave of the WIC Infant Feeding Practices Survey occurring later in FY11 has begun.

Activity 3: The contract with SUMA/Orchard Social Marketing, Inc. (SOSM) ended October 2010. No work with regard to food redemption or participant retention was conducted in the first half of FY11.

An attachment is included in this section. IVC_NPM14_Current Activities

c. Plan for the Coming Year

Activity 1: Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.

Output Measure(s): Number of WIC participants receiving nutrition education at time of benefit issuance. Type and number of activities included. Funding of WIC obesity projects. Funding registered dietitians at clinics to engage children at risk for obesity. Number of new mothers who choose to breastfeed.

Monitoring: Review quarterly WIC performance measure data on nutrition education contacts.

Activity 2: Support activities that address food consumption patterns in WIC families.

Output Measure(s): Type and number of activities; number of surveys/studies conducted to determine food consumption patterns. Reports and presentations of findings.

Monitoring: Track progress on activities, studies, and analyses.

Activity 3: Identify factors that affect the redemption rate for WIC participants and the length of time participants remain on the WIC program.

Output Measure(s): Type and number of activities included; summary report on factors identified.

Monitoring: Track progress on activities and review report.

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	2006	2007	2008	2009	2010
Annual Performance Objective	7.3	7.2	7.5	8	8
Annual Indicator	7.9	8.3	6.0	7.2	7.0
Numerator		32882	24517	28755	28698
Denominator		396167	405242	401610	411254
Data Source			PRAMS and Natality Data	PRAMS and Natality Data	PRAMS and Natality Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	6.9	6.8	6.6	6.4	6.2

Notes - 2010

PRAMS data for Texas are only available through 2009. The estimate for 2010 is a linear projection based on PRAMS data from 2002 through 2009. Denominator data are all live births. Birth estimates for 2010 are based on a linear projection using natality data from 2005 through 2008. Numerator data are calculated by multiplying the percent from PRAMS and the total number of live births.

Notes - 2009

PRAMS data for Texas are available through 2009. Denominator data are all live births. Natality data for 2009 is provisional. This indicator has been adjusted for final PRAMS data and provisional birth data. In the previous grant application, the denominator was based on a linear

trend. Numerator data are calculated by multiplying the percent from PRAMS and the total number of live births.

Notes - 2008

PRAMS data for Texas are available through 2009. Denominator data are all live births. Natality data are final for 2008. This indicator has been adjusted for final data. Numerator data are calculated by multiplying the percent from PRAMS and the total number of live births.

a. Last Year's Accomplishments

Activity 1: The DSHS Tobacco Prevention and Control Program (TPCP) distributed "Yes You Can" public service announcements (PSAs) throughout the state's TV markets. Through February 2010, a total of 1,686 PSAs ran in 7 Texas markets (Austin, Beaumont/Port Arthur, Corpus Christi, Dallas, El Paso, Houston, San Antonio) producing 2,754 gross ratings points at a value of \$348,470. TPCP received Title V funding to conduct media outreach targeting women who smoke. This media flight, which aired in the 6 media markets that coincide with coalition efforts, started April 26, 2010, as part of a two-week run-up to Mother's Day. The media flight continued through May 23, 2010 due to cost savings that allowed for an extension.

During the Mother's Day media flight, there were 579 callers to the Quitline from the 6 coalition media markets, which accounted for 58.4% of all calls. For May, the Quitline received 512 calls, with 315 of the calls (61.5%) coming from the 6 targeted markets. For the month of May, the Quitline received 303 calls from females, with 187 (61.7%) coming from the 6 targeted markets. As in April, exactly half of the pregnant women (4 of 8) who called in during the month of May were from the 6 areas.

The American Cancer Society conducts follow up surveys of callers to the Quitline. Recently, they found that approximately 27% of those receiving services successfully quit using tobacco. For those who called from the 6 targeted markets, 156 will be tobacco-free later this year. A study by the Center for Health Research at Kaiser Permanente found that for every Texan who quits smoking, there is a five-year savings of \$8,127 in medical costs and lost productivity. For this \$200,000 investment in media in 6 Texas communities, there is a potential return of \$1.26 million in reduced future medical costs and increased productivity.

Activity 2: According to 2008 PRAMS data, approximately 5.4% of teens of all races between the ages of 13-19 reported smoking in the last 3 months of pregnancy. For women of all races = age 20, approximately 6.2% reported smoking in the last 3 months of pregnancy. When examined by race, Whites have the highest rates, with approximately 18.7% of 13-19 year olds and approximately 10.6% of women over age 20 reporting smoking during the last 3 months of pregnancy.

Activity 3: A meeting was held to discuss the development of a training for promotores/community health workers regarding tobacco cessation during pregnancy. Discussion about training certification and working with a local training agency to pilot the training helped to shape the direction of the project. A training outline was developed and reviewed by Title V MCH staff. Title V MCH staff hired a graduate level intern to complete the development of the training based upon the outline that was developed.

Performance Assessment: Rates of smoking in the third trimester increased between 2008 and 2010. The nature of tobacco addiction may be a factor in this indicator. Efforts to impact this measure are currently underway, including expanding capacity to provide brief interventions for pregnant women.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Implement tobacco cessation social marketing campaign targeting pregnant women and expectant fathers.			X	
2. Monitor smoking rates in the last three months of pregnancy among adults and teens by race and ethnicity.				X
3. Develop training for promotoras/community health workers to provide information regarding smoking cessation during pregnancy.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The Yes You Can Quitline over-the-air TV campaign ran from December 27, 2010 through January 30, in Austin, Lubbock, and San Antonio. The target audience was adults age 25-49. 72.1% of the target market (a total of 1,119,524 adults 25-49) were exposed to the commercials an average of 6 times for 677,219 total impressions.

Cable TV was utilized for the Ft. Bend market, using the Katy, Sugarland, and Ft. Bend cable systems. Again the target audience was adults age 25-49. It is estimated that 55.1% of the target audience (64,846 adults 25-49) were exposed to the message an average of 2.1 times for 130,838 total impressions.

Activity 2: According to 2009 PRAMS data, approximately 5.6% of teens of all races between the ages of 13-19 smoked in the last three months of pregnancy. For women of all races over the age of twenty, approximately 7.4% 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 14.7% smoking in the third trimester. Approximately 12.3% of Black women and 12.2% of White women over the age of 20 smoked in the last three months of pregnancy.

Activity 3: In the first half of FY11, a master's level intern assisted in the development of this smoking cessation training, a draft was sent to internal DSHS stakeholders, and feedback was received and incorporated.

An attachment is included in this section. IVC_NPM15_Current Activities

c. Plan for the Coming Year

Activity 1: Support statewide tobacco prevention and cessation efforts that target men and women of childbearing age and their families.

Output Measure(s): Reports detailing media campaign impact; number of calls to Quitline resulting from activities; other activities that promote tobacco prevention and cessation.

Monitoring: Track activity progress and development of reports; review quarterly Health Service Region reports.

Activity 2: Monitor smoking rates in the last three months of pregnancy among adults and teens by race and ethnicity.

Output Measure(s): Written review of data, data review communicated to external stakeholders including March of Dimes, Healthy Start, WIC and Title V fee-for-service and population-based

providers; information on website, including referral resources for providers and clients.

Monitoring: Review birth record, PRAMS, and Texas BRFSS data as available.

Activity 3: Develop, implement, promote, and evaluate training for promotores/community health workers to provide smoking cessation interventions during pregnancy.

Output Measure(s): Training module developed and disseminated to approved organizations providing DSHS certified continuing education for promotores/community health workers; number of DSHS approved training programs adding the module to their approved curriculum; number of continuing education programs using the module held by DSHS approved training programs and number of participants trained; evaluation completed and documented.

Monitoring: Track development of module at regular work group meetings; track implementation of module through regular contact with the training programs and reports available on request.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	7.8	7.6	6	5.5	5.2
Annual Indicator	6.9	6.4	7.2	8.7	7.8
Numerator	125	118	134	163	141
Denominator	1810309	1840936	1866100	1882929	1810902
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
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
	2011	2012	2013	2014	2015
Annual	7.5	7.4	7.3	7.2	7.1

Performance Objective					
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Notes - 2010

Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 2003 through 2008.

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

Notes - 2009

Mortality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Denominator data provided by the Office of the State Demographer.

Notes - 2008

Mortality data reported for 2008 are final. This indicator has been adjusted for final data.

Denominator data provided by the Office of the State Demographer.

a. Last Year's Accomplishments

Activity 1: The Texas Suicide Prevention Council met to plan and implement the Texas State Plan for Suicide Prevention and serve as an advisory group to the Texas Youth Suicide Prevention Project (TYSP). Additionally, members discussed policy needs, updates from coalitions and agencies, recommendations for the 2010 Suicide Prevention Symposium, and plans for 2011.

The statewide symposium was held in June 2010. A planning committee was named and meetings were held in February and March 2010. Title V funding supported registration fees for 338 participants with the primary attendees being nonprofit, clinical, and mental health providers and school/university-related. National keynote speakers included M. David Rudd and Jason Kilmer. 100% of survey respondents rated the symposium as good to excellent.

TYSP screened 200 youth of which 45 screened positive and were further assessed. None of the youth were in imminent risk of danger to self or others. All youth were referred for outpatient mental health services in the community.

135,245 print materials (e.g. brochures, resource lists, and Question, Persuade, Respond (QPR) booklets) were distributed at workshops, exhibits, meetings, and conferences. 1,285 Texas Suicide Prevention and Postvention Toolkits were distributed. The toolkit is also available online at www.texassuicideprevention.org. The website also provided updates on suicide and mood disorders, resources, news and events, and volunteer opportunities.

14 suicide prevention awareness presentations were made at children's policy meetings, universities, the Texas Education Agency (TEA), community coalitions, and through webinars. 17 media contacts were made, including comments posted to internet blogs for the Associated Press; newspapers in Austin, San Marcos, Dallas, Brazos County, Westlake; various statewide newsletters; and 6 television stations. A written PSA was sent to 100 radio stations and a news conference was held. Information on prevention and postvention was given to community, school, and university representatives in more than 20 communities.

During FY10, MHAT developed the ASK nonproprietary curriculum, which was reviewed by Communities in Schools (CIS) and the Director of Guidance at TEA and the Education Service Centers (ESC). These agencies and the Texas Juvenile Probation Commission are integrating the curricula into their regular staff training. The suicide prevention training incorporates the concepts of the QPR training and information on the agency's protocols.

Regional Title V Staff participate in, or are developing, a Suicide Prevention Coalition. The Texas Panhandle Suicide Prevention Coalition met monthly and maintained a SharePoint site to share resources and provide a web-based networking site. Regional Title V staff participated in activities for National Suicide Prevention Week, attended the Suicide Prevention Symposium, and shared resources with School Health Advisory Councils and school districts.

Activity 2: 572 professionals and 282 community members received GateKeeper training or were provided educational materials by the school health specialists. School district staff, regional DSHS staff, and parents were among those receiving the information through workshops, awareness presentations, email communications, and site visits.

Activity 3: The Colorado/Austin/Waller Counties Child Fatality Review Team (CFRT) worked with school nurses to distribute suicide prevention cards in their respective school districts. These cards show how to respond to and identify being suicidal, and how to seek help. Teams developed suicide prevention coalitions in South Texas, Tyler, and Amarillo. DSHS CFRT exhibited at the Suicide Prevention Symposium on using local CFRT data to analyze local youth suicide data. The SCFRT worked on a position statement on Child Suicide to be released in FY11. The State CFR Coordinator presented in a webinar for Substance Abuse and Mental Health Services Administration staff on the Texas example of how CFR can be instrumental in suicide prevention efforts. The State CFR Coordinator distributed information on suicide prevention programs and research statewide to members of local and state teams, and regional DSHS staff.

Performance Assessment: With final data, rates have remained stable over time. The distribution of the suicide prevention toolkit and the ASK training in 2010 will help more people will recognize the signs of suicidality and know how to intervene.

An attachment is included in this section. IVC_NPM16_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide support to the internal and external stakeholder workgroups and coordination efforts addressing suicide prevention.				X
2. Provide Gatekeeper training and support for suicide prevention activities.			X	X
3. Report on suicide deaths of 15-17 year olds and CFRT activities to promote suicide prevention.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Mental Health America Texas developed "Texas Statutes Related to Suicide", an announcement about the 2011 Texas Suicide Prevention Symposium, and the January 2011 Texas Suicide Prevention eNewsletter on www.texasuicideprevention.org, which was sent to 2,000 subscribers. 225,007 printed materials were distributed.

Activity 2: 49 QPR and ASK trainings were conducted. 2,035 individuals were trained as gatekeepers and 17 as ASK Instructors. 19 exhibits on suicide prevention for youth were

conducted. 576 individuals were trained through the At-Risk Online Training for high schools.

Activity 3: The Suicide Prevention Council (SPC) met 3 times to plan the agenda for the symposium. A new local suicide prevention coalition was added in Carthage (serving 7 NE counties). The SPC provided consultation to Rockdale ISD, Leadership Milam, Travis Co. Coalition, Angelo State University, Austin ISD, Tarrant County College District, Alvin Community College, Brazoria Co. Suicide Prevention Coalition, Austin Mayor's Task Force and Austin/Travis County Youth Suicide Prevention Workgroup. DSHS regional staff participated in activities through community coalitions.

Activity 4: CFRTs reviewed 59 out of the 816 child suicides in 2008, which were analyzed in 2010 CFRT Annual Report. 9 East TX counties participate in the Save a Life Today (SALT) Suicide Prevention Coalition. The State CFRT Committee Position Statement on Child Suicide has been distributed and posted on the DSHS website.

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): Establish website for suicide prevention information and resources; number of public awareness activities implemented through the Garrett Lee Smith Texas Youth Suicide Prevention (TYSP) Grant.

Monitoring: Document updates for the website regarding suicide information and prevention; document public awareness activities conducted as part of the TYSP grant.

Activity 2: Provide training to individuals, communities, and schools to identify and refer youth at higher risk of suicide and suicide attempts.

Output Measure(s): Number of individuals, communities and school personnel trained in QPR (Question, Persuade, Refer) and/or ASK (Ask about suicide, Seek more information, Know how and where to refer); Number of high school personnel trained in At-Risk (At-Risk is an interactive, web-based training simulation to teach school staff to effectively identify, approach and refer students At-Risk of suicide or suicide attempts).

Monitoring: Documentation of QPR, ASK, and At-Risk trainings completed.

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

Output Measure(s): Participate in the Texas Suicide Prevention Council; Obtain information about the Suicide Prevention Coalitions established statewide; number of regional activities.

Monitoring: Review meeting notes from the Texas Suicide Prevention Council; document suicide prevention activities implemented by the Council; track the contact information of the Suicide Prevention Coalitions; document local suicide prevention activities; review quarterly Health Service Region staff reports.

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

Output Measure(s): Public awareness/educational materials developed; suicide deaths of youth 17 and younger reported in the State Child Fatality Review Team Committee annual report; number of trainings on developing suicide prevention initiatives presented to CFRTs; and number

of local initiatives developed by or participated in by CFRTs.

Monitoring: Track materials that are developed; provide updates of youth 17-and younger suicide deaths and local CFRT training and suicide prevention activities at quarterly State Committee meetings.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	55	55	52	52	52
Annual Indicator	49.4	48.2	50.2	47.0	47.9
Numerator	2786	2849	2946	2775	2999
Denominator	5639	5913	5865	5906	6263
Data Source			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.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	50	50	51	51.5	52

Notes - 2010

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 2010 are estimates. Estimates are linear projections based on data from 1996 through 2008.

Notes - 2009

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 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Notes - 2008

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 2008 are final. This indicator has been adjusted for final data.

a. Last Year's Accomplishments

Activity 1: At the MCH-Epidemiology conference in December 2009, discussion and dialogue was started with the key players in other states and at the Centers for Disease Control and Prevention (CDC) who are studying utilization of level III facilities for high-risk deliveries. It was determined that although the American Hospital Association (AHA) Annual Survey of Hospitals collects information on obstetric level, the Division of Reproductive Health at CDC uses the neonatal level of care to measure the percent of very low birth weight (VLBW) infants born in high-risk facilities. Texas will begin exploring additional ways to obtain neonatal level of care information. Title V MCH staff explored other state's definitions of levels of care, and definitions from the American Academy of Pediatrics for levels of care.

Activity 2: Stakeholder involvement was initiated. While Texas does not regulate or license hospitals for their obstetric or neonatal levels of care, Title V MCH staff explored ways to work with similar stakeholders such as the Texas Hospital Association and the DSHS Division for Regulatory Services. In June 2010, Title V MCH staff met with staff from DSHS Regulatory to discuss how the division works with hospitals and their rule making process. The meeting allowed for an opportunity to explore potential partnership in addressing the definition of hospital perinatal levels of care in Texas. It was determined that defining levels of care and implementing and/or enforcing adoption of these levels for the state would be the biggest challenge. Title V MCH staff began research into how other states have accomplished similar activities. Regulatory staff shared Hospital Licensing Rules.

Activity 3: In 2007, the most recent year that data is available, 2,202 (50.6%) singleton VLBW babies were born in a level III* hospital. For multiple VLBW births, 874 or 58.3% of those babies were born in a level III* hospital. In total, 3,076 or 52.6% of all VLBW births in Texas occurred at a level III* hospital.

In 2007, 310 mothers (5.2% of VLBW births) were transferred for maternal medical or fetal indications, and 796 infants (13.3%) were transferred within 24 hours of delivery.

*Level is based on AHA self-designated obstetric level.

Performance Assessment: Less than half of all deliveries of VLBW infants occurred at facilities for high risk deliveries and neonates. Efforts to engage external partners are underway to determine what steps are needed to further address this issue.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Communicate identified sociodemographic and geographic barriers for delivery of VLBW infants in high risk facilities to stakeholders, including March of Dimes, Texas Healthy Start Alliance, and health care professionals, and solicit feedback.				X
2. Communicate location and proximity of high risk perinatal care facilities to hospitals, health care professionals, and other stakeholders.				X
3. Monitor rate of very low birth weight infants delivered at facilities for high-risk deliveries and neonates through the analysis of previously collected data.				X
4.				
5.				
6.				
7.				
8.				
9.				

b. Current Activities

Activity 1: Staff reviewed literature and work from other states to determine existing best practices. After meeting with DSHS Regulatory Services last year, it was determined that pursuit of other partnerships will be necessary to move forward in exploring standard definitions for level of care. At the January 2011 Healthy Texas Babies Expert Panel meeting, staff networked with prenatal and labor and delivery health care providers who were interested in developing statewide definitions and standards for levels of care and testing those standards at a local/regional level.

Activity 2: A map of level III obstetric hospitals was created. The process entailed development of a list of hospitals that self-designated in response to the American Hospital Association (AHA) annual survey of hospitals.

Activity 3: In 2008, the most recent year that final birth data is available, 48.1% (n=2067) of singleton very low birth weight (VLBW) babies born in Texas to Texas residents were born in a level III* hospital. For multiple VLBW births, 56.0% (n=879) of those babies were born in a level III* hospital. In total, 50.2% (n=2946) of all VLBW births in Texas to Texas residents occurred at a level III* hospital.

In 2008, the mothers of 271 VLBW infants born in Texas (4.6% of VLBW births) were transferred for maternal medical or fetal indications, and 705 infants (11.9%) were transferred within 24 hours of delivery.

*Level is based on AHA self-designated obstetric level.

An attachment is included in this section. IVC_NPM17_Current Activities

c. Plan for the Coming Year

Activity 1: Develop partnerships with internal and external stakeholders (e.g. Texas DSHS Division for Regulatory Services, Texas Hospital Association) to explore 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: Update map of level III neonatal intensive care unit (NICU) hospitals in Texas and develop a promotion and distribution plan for sharing with partners.

Output Measure(s): Updated map of level III NICU hospital locations; promotion and distribution plan.

Monitoring: Document communication, promotion, and distribution.

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	2006	2007	2008	2009	2010
Annual Performance Objective	85	85	73	74	66
Annual Indicator	65.4	62.6	57.9	58.0	55.9
Numerator	255429	249155	234829	232782	230085
Denominator	390702	398319	405242	401610	411254
Data Source			Nativity Data	Nativity Data	Nativity Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	58	58	58.2	58.4	58.6

Notes - 2010

In 2005, Texas implemented the U.S. Certificate of Live Birth, 2003. This change had a significant impact on measure of prenatal care utilization. Estimates for 2010 are linear projections based on data from 2005 through 2008.

Notes - 2009

Nativity data from 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Notes - 2008

Nativity data from 2008 is final. This indicator has been adjusted for final data.

a. Last Year's Accomplishments

Activity 1: Title V MCH staff applied for a Centers for Disease Control and Prevention (CDC) Public Health Prevention Specialist (PHPS) to develop a strategic plan on preconception health. The position was not funded and staff explored other ways to address preconception health and early prenatal care. Staff was invited to and attended a Healthy Start Interconception meeting in June 2010 to begin work on addressing interconception care. After the meeting, the 6 healthy start sites agreed to work with DSHS to standardize their protocol and screening tool for perinatal depression to improve postpartum and interconception care in this area. In August 2010, a summit was held with the 6 sites and all agreed to work together to develop a standard screening protocol and to use the same screening tool (Edinburgh Postnatal Depression Scale) across all sites.

Regional staff continued to provide referrals for health care and social services to pregnant women through clinics and health fairs and collaboration with Healthy Start sites. Title V regional staff led the Healthy Baby Coalition, an effort in the Texas Panhandle to increase the number of

promotores or community health workers (CHWs) providing information and outreach to promote prenatal care and healthy birth outcomes in the region. Title V regional staff also participated in the Tarrant County Infant Mortality Network with a focus in 2010 on improving perinatal outcomes for teens. DSHS WIC implemented a project with the Tarrant County Public Health Department to address improved birth outcomes through the use of promotores/CHWs.

Activity 2: Staff worked with Healthy Start sites to collect and analyze data on prenatal care, perinatal depression, and client demographics. Technical assistance meetings were held with sites in October, November, and December 2009 to discuss data collection and secure data transfer. Data were submitted to DSHS in late January 2010 and preliminary analyses were completed. However, due to inconsistencies in the way data were collected and reported amongst the sites, analyses were limited to basic descriptive statistics. A draft report was completed by DSHS that outlined the project, goals, methods, challenges, and recommendations for continuing to work on quality improvement with Healthy Start sites. The report will be released to Healthy Start in mid-2011.

Staff worked with regional Title V staff to discuss prenatal care access in North Texas. Data requests regarding access to prenatal care for the region were submitted to OPDS in November 2009 and February 2010 and staff continues to provide technical assistance on program planning and community assessment.

According to 2008 PRAMS data, approximately 67.8% of women reported that they began prenatal care (PNC) in the first trimester, while approximately 57.6% received adequate PNC based on Kessner Adequacy of Prenatal Care index. In addition, 75.3% of women reported that they received PNC as early as they wanted. According to the 2007 Texas birth certificate, 61.3% of women received at least adequate PNC as defined by the Kotelchuck's Adequacy of Prenatal Care Utilization (APNCU) Index. The components of the APNCU index include the (1) Adequacy of Initiation of Prenatal Care, which is the month prenatal care began and (2) Adequacy of Received Services, which is the proportion of the number of PNC visits recommended by ACOG* received between initiation of PNC and delivery. Adequate prenatal care is defined as PNC begun by the 4th month and 80% - 109% of recommended visits received.

*The number of PNC visits recommended by ACOG differs based on weeks of gestation and when PNC began.

Performance Assessment: The percent of women receiving prenatal care in the first trimester decreased overall between 2008 and 2010. Title V continues to be a safety net for prenatal care, along with Medicaid and the CHIP Perinatal program. Regional staff works to ensure that women eligible for these services are enrolled. A focus on preconception care has the potential to further impact this measure because of the emphasis on planned pregnancies and early care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase awareness of the need for early prenatal care among women in the preconception period.			X	
2. Monitor percent of infants born to women who received early and adequate prenatal care through the analysis of previously collected surveillance data.				X
3.				
4.				
5.				
6.				
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8.				
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10.				

b. Current Activities

Activity 1: Staff participated in the Healthy Texas Babies Initiative to reduce infant mortality. Activities included research, participation in planning meetings, preparation of materials for expert panel members, and attendance at expert panel meeting.

To date, 6,266 women accessed prenatal care through Title V contractors. DSHS regional staff presented information on prenatal care to migrant Head Start teen mothers and provided referrals for pregnant women to CHIP Perinatal (500+), Medicaid (800+), and Women's Health Program (1,000+).

Activity 2: From 2009 PRAMS, 72.4% of women reported that they began PNC in the first trimester, and 77.2% reported that they received PNC as early as they wanted. According to the 2008 birth certificate, 234,829 (57.9%) women began PNC in the first trimester and 240,689 (60.7%) women received at least adequate PNC based on Adequacy of Prenatal Care Index.

Activity 3: Staff participated in 4 Medicaid Peer 2 Peer meetings. Staff worked with Healthy Start sites to standardize the tool and protocol for maternal depression screening. Healthy Start sites are collecting data to share with DSHS. Staff attended the Texas Office for the Prevention of Developmental Disabilities strategic planning meeting and advised the group to include preconception and interconception care in the plan.

DSHS regional staff provided TA for the Nurse Family Partnership site in Amarillo. A Community Prematurity Summit was held for key African American health leaders.

An attachment is included in this section. IVC_NPM18_Current Activities

c. Plan for the Coming Year

Activity 1: Increase infrastructure for improving access to prenatal care.

Output Measure(s): Number and type of strategies to increase infrastructure for improving access to prenatal care, including regional activities; number of women receiving prenatal care through Title V contractors.

Monitoring: Document strategies.

Activity 2: Monitor percent of infants born to women who received early and adequate prenatal care through the analysis of previously collected surveillance data.

Output Measure(s): Percent of infants born to women who received early and adequate prenatal care.

Monitoring: Review birth record and PRAMS data.

Activity 3: Increase DSHS engagement in preconception and interconception health.

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

Monitoring: Document efforts with partners and document initiatives DSHS is involved with pertaining to preconception and interconception health.

D. State Performance Measures

State Performance Measure 1: *Change in percentage of CYSHCN living in congregate care settings as percent of base year 2003.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	95	90	90	85	85
Annual Indicator	100.1	99.4	100.4	97.8	97.0
Numerator	1619	1608	1624	1582	1568
Denominator	1617	1617	1617	1617	1617
Data Source			Permanency Planning and Family Based Alt. Report	Permanency Planning and Family Based Alt. Report	Permanency Planning and Family Based Alt. Report
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	80	80	80	80	80

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 Services facilities.

Notes - 2009

Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature February 2010.

The FY09 number decreased from the base year 2003. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments. The number of children in Intermediate Care Facilities/Mental Retardation remained steady with slight decreases in other facility types.

Notes - 2008

Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2008.

The FY08 number exceeds the base year 2003. While the total number of children in institutions

as defined by SB368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments with two exceptions. The number of children in state mental retardation facilities, including state schools is increasing and the number of children in Department of Family and Protective Services (DFPS) is increasing.

a. Last Year's Accomplishments

Activity 1: CSHCN Services Program (SP) regional staff and contractors assisted 1,406 CYSHCN and their families with permanency planning. HHSC's Senate Bill (SB) 368 Permanency Planning Report noted that 1,568 children resided in institutions as of August 31, 2010. Of these, 692 children were recommended for transition to the community but had not yet transitioned. During this period, 173 children moved to less restrictive environments (other than family-based settings) and 124 children moved to family-based settings. Residential settings for children continued to shift to smaller, less restrictive environments.

Activity 2: CSHCN SP provided \$219,851 in fee-for-service Family Support Services (FSS) benefits that include respite, van modifications, and home modifications for 57 clients with health care benefits. CSHCN SP contractors provided workshops on important topics for CYSHCN and their families. Contractors provided funds for respite, equipment, supplies, counseling, and expenses not covered by other sources.

Contractors provided FSS to 1,641 CYSHCN and their families. In addition to respite, 10 community-based contractors provided funds for equipment, supplies, counseling, and medical expenses not covered by other sources. Contractors also hosted conferences, conducted support groups, and provided training for CYSHCN and their families.

Activity 3: CSHCN SP contractor, EveryChild, Inc. reviewed permanency plans for children in congregate care settings, developed screening tools to identify reasons for initial and continued placement in institutions, and identified supports needed to live successfully in the community. EveryChild prepared and released an extensive literature review "Precarious Pathways: Use of Residential Congregate Care by Children with Developmental Disabilities," by Nancy Rosenau, PhD, Executive Director, <http://www.everychildtexas.org/PDFs/Literature%20Review%20CC%202010.pdf>.

The Department of Aging and Disability Services (DADS) completed the transfer of Home and Community-based Services (HCS) Case Management services from service providers to local Mental Retardation Authorities. DADS received \$200,000 from the U.S. Administration on Aging under the federal Lifespan Respite Care Program, creating a Texas Respite Coordination Center to conduct statewide respite forums, compile an Inventory of Respite Services, and create best-practice toolkits for respite providers and a training toolkit for caregivers.

DADS' current FY 10-11 budget expanded the number served in community waiver services. However, the FY 12-13 base budget request will reverse the FY 10-11 expansion efforts and reduce the number served overall.

The Texas Lifespan Respite Care Program awarded funds to create three community-based pilot programs to promote respite for caregivers of individuals of all ages with chronic conditions and disabilities in Texas. An emphasis was on reaching isolated caregivers living in rural areas as well as Hispanic and Asian populations, and those not eligible for respite services through other programs.

CSHCN SP staff participated in community forums including the Children's Policy Council, Consumer-Directed Services Workgroup, Money Follows the Person state and regional workgroups, Promoting Independence Advisory Council, Texas Integrated Funding Initiative, and Texas Council for Developmental Disabilities. CSHCN SP contractors and regional staff participated in community forums, committee meetings, and local Community Resources Coordination Groups.

Performance Assessment: As of August 31, 2010, 1,568 children resided in institutions, 94% of the 2003 baseline number of 1,675, and represented a decrease of .88% from FY09. While the total number of children in institutions as defined by SB 368 has remained fairly steady, residential settings continue a shift to smaller, less restrictive environments. Barriers identified for CYSHCN living successfully in the community with families included: inadequate specialized community supports, medical services, attendant care, behavioral intervention, and respite. CSHCN SP was committed to permanency planning principles to support all CYSHCN living with families in communities. The data analysis conducted by EveryChild, Inc., will help identify opportunities for systems change and improvement in service delivery. CYSHCN will benefit from interagency collaboration of high level decision makers in the Task Force for Children with Special Needs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide, or support the provision of, permanency planning and case management services to families of CSHCN who reside in or at risk of placement in congregate care settings.		X		
2. Fund respite and other family support services through contracts and CSHCN SP Healthcare Benefits.		X		
3. Collaborate with contractors, state agencies, and other entities to support permanency planning and family-based living options for CSHCN 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 Services Program (SP) regional staff and contractors assisted 859 CSHCN and their families with permanency planning in the 1st half of FY11.

CSHCN Services Program (SP) contractor, EveryChild, Inc., continued its study on permanency planning for CYSHCN residing in or at risk of institutional placement. EveryChild completed a literature review which identified facilitating permanency planning as a most important intervention.

Activity 2: CSHCN SP contractors and health care benefits provided respite and other family support services to 1,292 children and families totaling 47,336 respite hours. In addition to sponsoring workshops and conferences for families, CSHCN SP contractors provided funds for respite, equipment, supplies, counseling, and expenses not covered by other sources to support children living at home.

Activity 3: Staff assisted in the development of the Health and Human Service Commission's "Feasibility Study for Providing Community Support and Residential Services for Individuals with Acquired Brain Injury" and the Texas Council for Developmental Disabilities, "Texas Biennial Disabilities Report" which recommended halting the admission of children to state schools.

Respite Care of San Antonio and CSHCN SP staff joined the Texas Respite Coalition advisory group. CSHCN SP contractor, Children's Special Needs Network collaborated with the Aging and Disability Resource Center and the Lifespan Respite Program to provide in-home respite for families.

An attachment is included in this section. IVD_SPM1_Current Activities

c. Plan for the Coming Year

Activity 1: Provide and assess the provision of permanency planning activities for families of CYSHCN who reside in or are at risk of placement in congregate care settings.

Output Measure(s): Number of CYSHCN assisted with permanency planning activities by CSHCN SP regional and contractor case management staff; information from HHSC Permanency Planning and Family-Based Alternatives Report (Senate Bill 368) such as 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 and placement in a family-based setting or placement in less restrictive environment other than a family-based setting, and trends in admission, discharge, placement; results of data analysis of permanency plans, as available.

Monitoring: Review quarterly regional activity reports, contractor quarterly reports, data from the HHSC Permanency Planning and Family-Based Alternatives Report (Senate Bill 368), and data analysis of permanency plans, as available.

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 services programs funded and promoted through CSHCN SP contracts; number of CYSHCN provided respite and other family support services (FSS) through CSHCN SP contractors and health care benefits; number of total respite hours provided by CSHCN SP contractors and health care benefits.

Monitoring: Review quarterly reports from the CSHCN SP health care benefits database and contractor quarterly reports.

Activity 3: Collaborate with public and private entities to 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.

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 reports on relevant meetings attended by CSHCN SP staff, contractor quarterly reports, and reports of other activities.

State Performance Measure 2: Rate of excess feto-infant mortality in Texas.

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance					

Objective					
Annual Indicator			1.6	1.5	1.5
Numerator					
Denominator					
Data Source			Natality and Mortality Data	Natality and Mortality Data	Natality and Mortality Data
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	1.5	1.5	1.4	1.4	1.3

Notes - 2010

This is a Perinatal Periods of Risk (PPOR) measure. PPOR is an approach to monitoring and investigating fetio-infant mortality utilized by the CDC and WHO, among others. The rate of excess fetio-infant deaths is the rate of fetio-infant deaths in Texas minus the rate among a reference group of non-Hispanic white women, aged 20+ with 13+ years of education.

Calculations use the 1998-2000 external national reference group value of 5.9/1,000 live births <http://webmedia.unmc.edu/community/citymatch/PPOR/NationalDataTables98-00/Table6.pdf> (includes non-Hispanic white women, aged 20+ with 13+ years of education)

Natality, Mortality, and Fetal death data for 2010 are estimated. Estimates are based on a linear trend of final data from 2005-2008 and provisional data from 2009.

Indicator = 7.4/1,000 live births (Texas)- 5.9/1,000 live births (Reference) = 1.5/1,000 live births

Notes - 2009

This is a Perinatal Periods of Risk (PPOR) measure. PPOR is an approach to monitoring and investigating fetio-infant mortality utilized by the CDC and WHO, among others. The rate of excess fetio-infant deaths is the rate of fetio-infant deaths in Texas minus the rate among a reference group of non-Hispanic white women, aged 20+ with 13+ years of education.

Calculations use the 1998-2000 external national reference group value of 5.9/1,000 live births <http://webmedia.unmc.edu/community/citymatch/PPOR/NationalDataTables98-00/Table6.pdf> (includes non-Hispanic white women, aged 20+ with 13+ years of education)

Natality, Mortality, and Fetal death data for 2010 are provisional.

Indicator = 7.4/1,000 live births (Texas)- 5.9/1,000 live births (Reference) = 1.5/1,000 live births

Notes - 2008

This is a Perinatal Periods of Risk (PPOR) measure. PPOR is an approach to monitoring and investigating fetio-infant mortality utilized by the CDC and WHO, among others. The rate of excess fetio-infant deaths is the rate of fetio-infant deaths in Texas minus the rate among a reference group of non-Hispanic white women, aged 20+ with 13+ years of education.

Calculations use the 1998-2000 external national reference group value of 5.9/1,000 live births <http://webmedia.unmc.edu/community/citymatch/PPOR/NationalDataTables98-00/Table6.pdf> (includes non-Hispanic white women, aged 20+ with 13+ years of education)

Natality, Mortality, and Fetal death data for 2008 are final.

Indicator = 7.5/1,000 live births (Texas)- 5.9/1,000 live births (Reference) = 1.6/1,000 live births

a. Last Year's Accomplishments

The current State Performance Measure is new for FY11. Please see attachment for the accomplishments of the previous State Performance Measure in FY10.

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. Identify excess fetio-infant mortality using the Perinatal Periods of Risk (PPOR) map.				X
2. Complete analyses to identify and prioritize factors with greatest contribution to fetio-infant death disparities.				X
3. Communicate findings of PPOR analyses to stakeholders.				X
4. Develop and disseminate materials and activities aimed at increasing awareness about infant health promotion and prevention of fetio-infant mortality.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: MCH staff attended a CityMatCH PPOR Workshop. State and regional Phase I analyses were completed for years 2005-2008. There were an estimated 4,213 excess fetio-infant deaths. The PPOR map indicated that 1,807 excess deaths were attributable to maternal health/prematurity, 897 to maternal care, 427 to newborn care, and 1,081 to infant health.

Activity 2: Distribution of excess death was mapped by race/ethnicity and by health service regions (HSRs). Notable disparities in excess fetio-infant death for 6 HSRs (with HSR 2 having the highest rate of excess death) and for black infants were observed.

Activity 3: Dissemination planning meeting scheduled later in FY11.

Activity 4: MCH staff participated in and coordinated multiple infant health workgroups, committees, and partnerships; delivered 4 professional presentations; launched online Safe Sleep trainings delivered to all Texas Child Protective Services case workers; developed trainer's manual for smoking cessation for pregnant women, draft Child Fatality Review Team annual report, and Texas Infant Sleep Survey fact sheet; continued to receive reports of Safe Sleep pilot community trainings and evaluations; distributed educational materials; and participated in drafting indicators for quality-based hospital care. Core team and project management meetings held for Healthy Texas Babies initiative and an Expert Panel summit was convened. A document of expert panel recommendations was developed and feedback was solicited.

An attachment is included in this section. IVD_SPM2_Current Activities

c. Plan for the Coming Year

Activity 1: Identify excess fetio-infant mortality using the Perinatal Periods of Risk (PPOR) map.

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

Monitoring: PPOR map.

Activity 2: Complete analyses to identify and prioritize factors with greatest contribution to fetoinfant death disparities.

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

Monitoring: Document analyses and priorities.

Activity 3: Communicate findings of PPOR analyses to stakeholders.

Output Measure(s): Communications developed; communications disseminated; number and types of stakeholders; number and types of feedback received.

Monitoring: Document communication and feedback received.

Activity 4: In conjunction with Healthy Texas Babies and other initiatives, develop and disseminate materials and activities aimed at increasing awareness about infant health promotion and prevention of fetoinfant mortality.

Output Measure(s): Public awareness, educational materials, and activities developed; dissemination methods identified; materials and information disseminated.

Monitoring: Document materials, activities, and dissemination methods; review quarterly Health Service Region reports.

State Performance Measure 3: *The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2011	2012	2013	2014	2015
Annual Performance Objective					

Notes - 2010

The MCH survey assessing program readiness and capacity to address mental and behavioral health has not been conducted. The survey is currently being administered. The results of the survey will be available and ready for dissemination by September 1, 2011.

a. Last Year's Accomplishments

The current State Performance Measure is new for FY11. Please see attachment for the accomplishments of the previous State Performance Measure in FY10.

An attachment is included in this section. IVD_SPM3_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess current level at which programs are working to enhance statewide capacity to address mental and behavioral health for MCH population.				X
2. Develop cross divisional opportunities for programs to increase capacity in addressing mental and behavioral health in MCH populations.				X
3. Partner with internal and external partners to enhance and incorporate mental and behavioral health for MCH populations into their efforts.				X
4. Increase opportunities to enhance and improve the quality of the data sources related to mental and behavioral health.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: MCH staff met to discuss the survey, target audience, and potential questions. A timeline was established for survey development and administration.

Activity 2: The Division for Mental Health and Substance Abuse, WIC, and the Texas Office for Prevention of Developmental Disabilities participated in an effort to develop best practice guides for providers on domestic violence. Staff attended the Perinatal HIV Consortium meetings held by the Division for Prevention and Preparedness.

Activity 3: Staff participated in the Primary Prevention Planning and Steering Committees and meetings with a grant officer and the PI for a sexual assault needs assessment. Staff participated in the Texas Leadership Team (LT) and the Virtual Council, Project Connect (PC) efforts to integrate public health and violence prevention. Staff presented the results of the Best Practices (BP) survey at a PC meeting that included Federal Family Violence Prevention Fund staff and to a group of PhD students at a vital stats meeting. PC agreed to assist with implementation and piloting of the BP survey. Staff consulted with the Regional CDC Assignee working along the border on violence issues. Staff presented information about the BP guide at the Healthy Start Annual Conference.

Activity 4: Reproductive coercion questions were added to PRAMS. Healthy Start sites agreed to standardize their collection of maternal depression screening data and share it with DSHS for analysis.

An attachment is included in this section. IVD_SPM3_Current Activities

c. Plan for the Coming Year

Activity 1: Assess current level at which programs are working to enhance statewide capacity to address mental and behavioral health for MCH population.

Output Measure(s): Number of surveys distributed to MCH programs; number and type of MCH programs responding to survey; assess what has already been accomplished by the Mental Health Transformation work group efforts and other efforts around the agency.

Monitoring: Review of annual survey results.

Activity 2: Develop cross divisional opportunities for programs to increase capacity in addressing mental and behavioral health in MCH populations.

Output Measure(s): Number of cross divisional partnerships; number and type of activities implemented.

Monitoring: Summary of partnerships and activities.

Activity 3: Partner with internal and external partners to enhance and incorporate mental and behavioral health for MCH populations into their efforts.

Output Measure(s): Number of meetings and types of partners engaged; number and type of activities implemented.

Monitoring: Document meetings or plans developed with partners.

Activity 4: Increase opportunities to enhance and improve the quality of the data sources related to mental and behavioral health.

Output Measure(s): Number of data sources that collect information about mental and behavioral health.

Monitoring: Use of data in reports, grants, and other documents; review quarterly Health Service Region reports.

State Performance Measure 4: *The percent of women between the ages of 18 and 44 who are current cigarette smokers.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	17.5	17	16.5	16	15.5
Annual Indicator	15.9	18.1	15.7	15.0	14.7
Numerator	733256	846808	743014	720955	725788
Denominator	4613620	4666871	4732576	4806369	4937333
Data Source			Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	14.5	14.5	14	13.5	13

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. BRFSS data for 2010 is estimated. Estimates are linear projections based on data from 2005 through 2009. Denominator data is projected by the Office of the State Demographer.

Notes - 2009

This indicator has been adjusted for final data. BRFSS is a sample survey, therefore, the numerator and denominator are not available. The annual indicator is the point estimate of the data collected after weighting. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by multiplying the percent from BRFSS and the total number of women 18 to 44 years of age.

Notes - 2008

BRFSS is a sample survey, therefore, the numerator and denominator are not available. The annual indicator is the point estimate of the data collected after weighting. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by multiplying the percent from BRFSS and the total number of women 18 to 44 years of age.

a. Last Year's Accomplishments

Activity 1: The "Yes You Can" Clinical Toolkits (Toolkits) were produced, with 1,500 Toolkits distributed to 6 statewide Tobacco Prevention and Control Coalitions (TPCCs) and 11 Prevention Resource Centers (PRCs) throughout the state. TPCCs and PRCs distributed these Toolkits and CDs containing downloadable files of the Toolkit materials to physicians and health care professionals in their respective regions. The Toolkit was made available to be downloaded from the "Yes You Can website", www.yesquit.org, by the general public as well as health care providers. The Texas Tobacco Prevention and Control Program (TCP) also began to distribute "Yes You Can" TV commercials as Public Service Announcements (PSAs) throughout the state's TV markets. The TCP received an added-value report on the Title-V Yes You Can TV Commercials that ran April-June 2010 as PSAs. The commercials ran a total of 5,662 times free of charge throughout the state during that time period.

Activity 2: Attendees at Minors and Tobacco sessions for FY10 included 47,999 youth and 29,296 adults. Tobacco cessation materials were distributed to 56,452 adults in FY10.

Activity 3: According to 2008 PRAMS data, in the 3 months before pregnancy, approximately 14% of women between 18-44 reported smoking. The rates were much higher for Whites (approximately 22.5%) than for Blacks (13.2%) and Hispanics (7.3%). While approximately 10.4% of women 18-44 of all races smoked in the 3 months after pregnancy, rates were again higher for Whites (13.3-20.0%) than Blacks (8.4-15.2%) and Hispanics (2.6-7.4%).

According to Texas Behavioral Risk Factor Surveillance System (BRFSS) data, in 2009 approximately 14.1% of women between the ages of 18-44 reported they were current smokers.

Performance Assessment: The rate of tobacco use among women 18-44 years of age declined between 2008 and 2010. Tobacco prevention is integrated into a variety of public health efforts and this has contributed to the decline in this measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide smoking cessation training using the Yes You Can Clinical Toolkit to healthcare professionals using Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Center staff.			X	
2. Distribute cessation and secondhand smoke educational materials through Texas Tobacco Prevention and Control			X	

Coalitions and regional Prevention Resource Centers.				
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: There were 1,200 cessation trainings using the Yes You Can Toolkits and 911 fax referrals to the Quitline in the first half of FY11.

Activity 2: There were 1,283 cessation and secondhand smoke educational meetings through the TPCCs and PRCs with a folder of written materials delivered at each presentation. While data are not available for the entire reporting period, 2,890 cumulative unique visits were made to the yestoquit.org website with an average of 4,359 page views for December 2010 through February 2011.

Activity 3: According to 2009 PRAMS data, in the 3 months before pregnancy, the percent of women between 18-44 who smoked was approximately 20%. The rates were much higher for Whites (29.3%) than for Blacks (22.4%) and Hispanics (12.3%). While approximately 13% of women 18-44 of all races smoked in the 3 months after pregnancy, rates were higher for Whites (20.7%) than Blacks (19.4%) and Hispanics (6.5%). According to BRFSS data, in 2009 14.1% of women between the ages of 18-44 were current smokers.

An attachment is included in this section. IVD_SPM4_Current Activities

c. Plan for the Coming Year

Activity 1: Provide tobacco cessation resources and support to partners working on efforts to improve maternal and child health.

Output Measure(s): Number of trainings held; number of resources distributed; number of referrals to Quitline by partners.

Monitoring: Quarterly total of training sessions held; resources distributed; and Quitline referrals made.

Activity 2: Distribute cessation and secondhand smoke educational materials through Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Centers.

Output Measure(s): Number and type of materials distributed.

Monitoring: Number of materials distributed and the number of hits to yesquit.org website.

Activity 3: Monitor smoking rates among women age 18-44 by race and ethnicity and by pregnancy status through the analysis of previously collected surveillance data.

Output Measure(s): Percent of women aged 18-44 who smoke by race and ethnicity, percent of women who smoked prior to pregnancy, percent of women who smoked during pregnancy, and percent of women who smoke in the postnatal period.

Monitoring: Review birth record, PRAMS, and Texas BRFSS data as available.

State Performance Measure 5: *The percent of obesity among school-aged children (grades 3-12).*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator			37.1	39.3	39.4
Numerator			1432960	1529673	1508282
Denominator			3865559	3894222	3831601
Data Source			School Physical Activity & Nutrition Survey	School Physical Activity & Nutrition Survey	School Physical Activity & Nutrition Survey
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	38	38	37	37	36

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 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).

Denominator data is a 2010 population projection from the Office of the State Demographer.

Notes - 2009

School Physical Activity & Nutrition Survey (SPAN) is a sample survey. The annual indicator is the point estimate of the data collected after weighting.

Numerator data are calculated by multiplying the percent of 4th, 8th, and 11th grade student children who are overweight or obese from SPAN 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).

Denominator data is from the Office of the State Demographer.

Notes - 2008

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 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).

Denominator data is from the Office of the State Demographer.

a. Last Year's Accomplishments

The current State Performance Measure is new for FY11. Please see attachment for the accomplishments of the previous State Performance Measure in FY10.

An attachment is included in this section. IVD_SPM5_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the School Physical Activity Nutrition (SPAN) workgroup to examine demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th grade children and their parents, 8th graders and 11th graders.				X
2. Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent school-aged childhood obesity.				X
3. Disseminate information and resources about the prevalence and risk factors associated with school-aged childhood obesity.			X	
4. Coordinate and implement regional and local childhood obesity prevention activities.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Data collection for the SPAN survey was completed. 398 schools participated in data collection across the state of Texas. Currently, data are being cleaned and the basic analyses will be available by the end of March 2011.

Activity 2: DSHS Nutrition, Physical Activity, and Obesity Prevention (NPAOP) and School Health Program worked with Texas AgriLife Extension, Texas Education Agency (TEA) and HHSC Office for the Elimination of Health Disparities (OEHD) on the ARRA/Communities Putting Prevention to Work (CPPW) Component I obesity project, which promotes evidence-based policies and interventions at state and local levels to establish healthy social norms.

Activity 3: School health specialists distributed information on childhood obesity prevention, nutrition, and physical activity to 101,233 individuals across Texas, including 94,865 teachers and administrators.

Activity 4: DSHS regional staff promoted physical activity and nutrition with local initiatives, and shared data or participated in obesity prevention activities at over 200 events. NPAOP, Title V, and the Office of Border Health funded 5 organizations for policy and environmental change

related to physical activity and nutrition. Technical assistance visits have been conducted by DSHS staff. Community projects include limiting TV time, walkability assessments, creating new walking trails, and advocating for more fruits and vegetables on children's menus at local restaurants

An attachment is included in this section. IVD_SPM5_Current Activities

c. Plan for the Coming Year

Activity 1: Collaborate with the School Physical Activity Nutrition (SPAN) workgroup to examine demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th grade children and their parents, 8th graders and 11th graders.

Output Measure(s): Prevalence of overweight and obesity among Texas school children by grade, gender and race/ethnicity; analysis to identify sociodemographic, social, and mental health correlates of obesity.

Monitoring: Monthly meetings to review study progress and outline dissemination activities.

Activity 2: Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent school-aged childhood obesity.

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

Monitoring: Quarterly review of implemented activities and overall progress.

Activity 3: Disseminate information and resources about the prevalence and risk factors associated with school-aged childhood obesity.

Output Measure(s): Number, type, and format of materials provided.

Monitoring: Quarterly review of information and resources distributed.

Activity 4: Coordinate and implement regional and local childhood obesity prevention activities.

Output Measure(s): Number and type of activities coordinated or implemented by Health Service Region Staff; number of childhood obesity prevention activities provided through the Education Service Centers.

Monitoring: Review quarterly Education Service Center progress reports; review quarterly Health Service Region reports.

State Performance Measure 6: *Rate of preventable child deaths (0-17 year olds) in Texas.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator			14.1	14.5	14.7
Numerator			917	954	907

Denominator			6495224	6557436	6179238
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
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	14	14	13.8	13.8	13.6

Notes - 2010

Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 2005 through 2008.

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

Notes - 2009

Mortality data reported for 2009 is provisional.

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

Notes - 2008

Mortality data reported for 2008 is final.

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

a. Last Year's Accomplishments

The current State Performance Measure is new for FY11. Please see attachment for the accomplishments of the previous State Performance Measure in FY10.

An attachment is included in this section. IVD_SPM6_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand Child Fatality Review (CFR) to cover more children in Texas to increase the understanding of risk and protective factors.				X
2. Develop and implement a plan to increase the number of preventable child deaths reviewed, improve the quality of CFR data collected and analyze data for recommendations of prevention activity direction, and other methods of dissemination.				X
3. Organize and facilitate internal and external stakeholders to address prevention of child drowning deaths.				X
4. Organize and facilitate internal and external stakeholders to address standardization of infant death scene investigations.				X
5.				
6.				
7.				
8.				
9.				

10.				
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b. Current Activities

Activity 1: Seven inquiries were made about starting new CFR teams (CFRT) and 2 new teams were formed in the first half of FY11. The CFR Coordinator exhibited at a two-day conference, resulting in inquiries about CFRT from counties that currently do not have a team. One existing CFRT is still working on expanding to include 6 more counties. At end of the reporting period, there were 97 CFRT that cover 197 counties. 6.7% of children live in county without CFRT.

Activity 2: The Data Quality Workgroup was formed. Data were analyzed and used in the 2010 Annual CFR Report. Data were used in creation of an exhibit and preparation of fact sheets on two injury topics. Consultation with National Center on Child Death Review occurred on data quality issues.

Activity 3: The Statewide Drowning Prevention Task Force is being formed. The State CFRT Committee developed 2 recommendations specific to drowning prevention: a law requiring 4-sided fencing on new residential pools and a law designating April as Water Safety Awareness Month.

Activity 4: The Statewide SUIDI Workgroup is being formed. State CFRT Committee recommended to the governor that the Department of Family and Protective Services be an integral part of the effort to improve and standardize infant death scene investigations.

An attachment is included in this section. IVD_SPM6_Current Activities

c. Plan for the Coming Year

Activity 1: Expand Child Fatality Review (CFR) to cover more children in Texas to increase the understanding of risk and protective factors.

Output Measure(s): Numbers of inquiries about new teams; CFR presentations conducted; number of newly-formed teams that review fatalities; number and type of activities coordinated or implemented by Health Service Region Staff.

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

Activity 2: Develop and implement a plan to increase the number of preventable child deaths reviewed, to improve the quality of the CFR data collected and to analyze data for Annual Report for recommendations of prevention activity direction, and other methods of dissemination.

Output Measure(s): Form Data Quality Workgroup in State CFRT Committee; create Data Quality Plan; deliver trainings on data collection and quality; and use 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 quarterly.

Activity 3: Organize and facilitate internal and external stakeholders to address prevention of child drowning deaths.

Output Measure(s): Form Statewide Drowning Prevention Task Force to develop state plan to reduce drowning deaths.

Monitoring: Quarterly report from Task Force on progress.

Activity 4: Organize and facilitate internal and external stakeholders to address standardization of

infant death scene investigations.

Output Measure(s): Establishment of Texas Sudden Unexpected Infant Death Investigation (SUIDI) Workgroup.

Monitoring: Quarterly reporting from Texas SUIDI Workgroup on progress.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2011	2012	2013	2014	2015
Annual Performance Objective					

Notes - 2010

The MCH survey assessing program utilization of research findings and/or evidence-based practices for program improvement and development has yet to be conducted. The survey is currently being administered. The results of the survey will be available and ready for dissemination by September 1, 2011.

a. Last Year's Accomplishments

The current State Performance Measure is new for FY11. Please see attachment for the accomplishments of the previous State Performance Measure in FY10.

An attachment is included in this section. IVD_SPM7_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess current level at which programs are working to identify research findings and/or evidence-based practices for improving DSHS programs serving MCH populations.				X
2. Increase cross-divisional opportunities to promote research findings and/or evidence-based practices in DSHS programs serving MCH populations.				X
3. Partner with external and internal stakeholders to identify opportunities to incorporate research findings/evidence-based practices.				X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

Activity 1: MCH staff met to determine the content, timeline, and population for the program survey that will be distributed to other DSHS programs on the use of research findings and/or evidence-based practices. The questionnaire is currently being refined to ensure question clarity.

Activity 2: MCH subject matter experts and researchers have been working with other programs within DSHS to promote the use of research findings and/or evidence-based practices. This includes programs within the Divisions of Family and Community Health Services, Prevention and Preparedness, and Mental Health Substance Abuse. Following the completion of the DSHS program survey, more targeted opportunities for cross-divisional collaboration will be identified to help increase the use of evidence-based practices.

Activity 3: MCH staff work with multiple stakeholders to explore opportunities to ensure that research findings/evidence-based practices are used as the primary mode of intervention or that information delivered to providers, professionals, and the general public are based on the most recent research or are best practices. Examples include implementing evidence-based youth development strategies to improve sexual and reproductive health among adolescents; the development of best practice guides for providers on domestic violence, substance abuse, and mental health; and implementation of evidence-based policies to support worksite lactation programs.

An attachment is included in this section. IVD_SPM7_Current Activities

c. Plan for the Coming Year

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

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

Monitoring: Review of annual survey results; documentation of materials/products distributed and activities completed.

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

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

Monitoring: Documentation of materials/products distributed and activities completed.

Activity 3: Partner with external and internal stakeholders to identify opportunities to incorporate research findings/evidence-based practices into programs.

Output Measure(s): Number of meetings and types of partners engaged; number and type of proposals developed for implementation; number and type of activities implemented.

Monitoring: Review meeting notes; copy of materials/plan developed.

E. Health Status Indicators

Introduction

The HSIs identify areas of success and concern. The percent of low birth weight (LBW) births have increased which may be explained by increases in multiple births because the percentage of LBW singleton births was the same in 2008 and 2009. Fatalities from unintentional injuries and motor vehicle crashes (MVC) decreased, as did the rate of nonfatal unintentional injuries among children 14 and younger and nonfatal MVC among 15 to 24 year olds. However, the nonfatal MVC among children 14 and younger increased. This indicator will be vital to understand the impact of future injury prevention, especially regarding motor vehicle safety for young children. Chlamydia rates continue to rise in Texas and the nation, indicating a continued need for increased attention to prevention activities focusing on women 15 to 44.

//2012/ The percent of very low birth weight (VLBW) births remained constant 2006 - 2010. Fatalities from unintentional injuries and motor vehicle crashes (MVC) decreased 2006 - 2010 among all age groups. //2012//

Texas is one of the only states to have population in urban, rural, and border areas. The majority of Texans reside in urban areas; however a sizable rural population still requires accessible services. Texas is also experiencing a demographic shift, being one of the states with the youngest overall population with a growing Hispanic segment that will become the largest population group among children by 2015. It will be increasingly important to consider the role of acculturation in health promotion and disease prevention and to ensure that interventions are appropriately tailored to Texas' unique needs.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	8.3	8.5	8.4	8.5	8.6
Numerator	32453	33834	34230	34137	36218
Denominator	390702	398319	405244	401610	418873
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 - 2010

All natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1996 through 2008.

Notes - 2009

All natality data reported for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Notes - 2008

All natality data reported for 2008 are final. This indicator has been adjusted for final data.

Narrative:

Low birth weight has steadily increased since 2000 moving further away from the Healthy People 2010 Objective of 5.0%. Between 2005 and 2009 (projected), there has been a 4.8% increase in this measure. In 2009 (projected), singletons accounted for 77.0% of all low birth weight, essentially unchanged from 77.3% in 2005. Given the relative consistency in the percent of very low birth weight deliveries among singleton births, the increase in very low birth weight deliveries among multiple births may contribute to the increase in this measure. Women receiving WIC and/or family planning services receive positive preconception health messages. The Texas Birth Defects Program works to ensure that women are aware of the need for folic acid supplementation prior to conception and in early pregnancy. Other programs throughout DSHS including the Tobacco Prevention and Control Program; Diabetes Program; and the Nutrition, Physical Activity, and Obesity Prevention Program also contribute to this measure by encouraging women to adopt the most beneficial health behaviors which support healthy fetal development.

//2012/ Between 2006 and 2010 (projected), there has been a 3.6% increase in this measure. The Healthy Texas Babies Initiative includes activities and interventions based on current research that strive to improve birth outcomes in Texas, such as preterm birth, low birth weight, and infant mortality. //2012//

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	6.5	6.7	6.7	6.7	6.9
Numerator	25021	26146	26458	26081	27801
Denominator	383887	391349	392755	388749	405495
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 - 2010

All natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1996 through 2008.

Notes - 2009

All natality data reported for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Notes - 2008

All natality data reported for 2008 are final. This indicator has been adjusted for final data.

Narrative:

Low birth weight among singletons has increased nearly every year since 2005. Between 2005 and 2009 (projected), there has been a 3.0% increase in this measure. The percent of singleton infants born low birth weight remained the same for 2008 and 2009, indicating that the increase in this indicator may be beginning to level off. Women receiving WIC and/or family planning services

receive positive preconception health messages. The Texas Birth Defects Program works to ensure that women are aware of the need for folic acid supplementation prior to conception and in early pregnancy. Other programs throughout DSHS including the Tobacco Prevention and Control Program; Diabetes Program; and the Nutrition, Physical Activity, and Obesity Prevention Program also contribute to this measure by encouraging women to adopt the most beneficial health behaviors which support healthy fetal development.

//2012/ Low birth weight among singletons has increased by 6.2% between 2006 and 2010 (projected), although the percent of singleton infants born low birth weight remained the same for 2007-2009.

The Healthy Texas Babies Initiative includes activities and interventions based on current research that strive to improve birth outcomes in Texas, such as preterm birth, low birth weight, and infant mortality. //2012//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	1.5	1.5	1.5	1.5	1.5
Numerator	5788	6097	5924	5938	6302
Denominator	390702	398319	405244	401610	418873
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 - 2010

All natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1996 through 2008.

Notes - 2009

All natality data reported for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Notes - 2008

All natality data reported for 2008 are final. This indicator has been adjusted for final data.

Narrative:

Very low birth weight has seen minimal increases since 2005, indicating that the percent of infants born very low birth weight is starting to level off in Texas. Between 2005 and 2009 (projected), there was a 6.7% increase in very low birth weight deliveries, which equates to a 0.1 percentage point increase. The percent of very low birth weight deliveries in 2009 (projected) was 77.7% higher than the Healthy People 2010 Objective (0.9%). Given the relative consistency in the percent of very low birth weight deliveries among singleton births, the increase in very low birth weight deliveries among multiple births may contribute to the increase in this measure. Women receiving WIC and/or family planning services receive positive preconception health messages. The Texas Birth Defects Program works to ensure that women are aware of the need for folic acid supplementation prior to conception and in early pregnancy. Other programs

throughout DSHS including the Tobacco Prevention and Control Program; Diabetes Program; and the Nutrition, Physical Activity, and Obesity Prevention Program also contribute to this measure by encouraging women to adopt the most beneficial health behaviors which support healthy fetal development.

/2012/ The percent of very low birth weight deliveries in 2010 (projected) was 66.7% higher than the Healthy People 2010 Objective (0.9%).

The Healthy Texas Babies Initiative includes activities and interventions based on current research that strive to improve birth outcomes in Texas, such as preterm birth, low birth weight, and infant mortality. //2012//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	1.1	1.1	1.1	1.1	1.1
Numerator	4207	4437	4335	4387	4662
Denominator	383887	391349	392755	388749	405495
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 - 2010

All natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1996 through 2008.

Notes - 2009

All natality data reported for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Notes - 2008

All natality data reported for 2008 are final. This indicator has been adjusted for final data.

Narrative:

Among singleton births, there has been minimal change in the percent of very low birth weight deliveries. There has been a slight 0.1 percent point increase in 2009 (projected), but no change from 2005 to 2008. This rate is higher than the Healthy People 2010 Objective of 0.9%. Women receiving WIC and/or family planning services receive positive preconception health messages. The Texas Birth Defects Program works to ensure that women are aware of the need for folic acid supplementation prior to conception and in early pregnancy. Other programs throughout DSHS including the Tobacco Prevention and Control Program; Diabetes Program; and the Nutrition, Physical Activity, and Obesity Prevention Program also contribute to this measure by encouraging women to adopt the most beneficial health behaviors which support healthy fetal development.

/2012/ Among singleton births, there has been no change in the percent of very low birth

weight deliveries since 2006.

The Healthy Texas Babies Initiative includes activities and interventions based on current research that strive to improve birth outcomes in Texas, such as preterm birth, low birth weight, and infant mortality. //2012//

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 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	9.3	9.3	8.7	8.8	9.1
Numerator	491	496	471	478	466
Denominator	5287340	5332129	5384151	5449069	5117214
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 - 2010

All mortality data reported for 2010 is estimated. Estimates are based on a linear trend of data from 1999 through 2008.

Denominator data projected by the Office of the State Demographer.

Notes - 2009

All mortality data reported for 2008 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Denominator data provided by the Office of the State Demographer.

Notes - 2008

All mortality data reported for 2008 is final. This indicator has been adjusted for final data.

Denominator data provided by the Office of the State Demographer.

Narrative:

The death rate for unintentional injuries for children aged 14 years and younger declined each year between 1999 and 2009 (projected). The number of unintentional injury fatalities declined to under 500 for the first time in 2005. Due to limitations in the TVIS system, the number of deaths reported for 2005 was based on an estimate and was entered into the system several years ago. TVIS does not allow data entry for years prior to 2007. The final number of deaths to children 14 years old and younger was 490 in 2005. Projections suggest that in 2009 the rate of unintentional injury fatalities declined to 8.9 per 100,000 children aged 14 years and younger. The network of local child fatality review teams throughout Texas and DSHS programs focusing on injury prevention have contributed to the decline in this measure.

//2012/ The death rate for unintentional injuries for children aged 14 years and younger declined overall between 2006 and 2010 (projected).

Local child fatality review teams throughout Texas and DSHS programs continue a focus on injury prevention. //2012//

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 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	4.9	4.7	3.5	3.7	3.9
Numerator	259	248	188	200	200
Denominator	5287340	5332129	5384151	5449069	5117214
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 - 2010

All mortality data reported for 2010 is estimated. Estimates are based on a linear trend of data from 1999 through 2008.

Denominator data projected by the Office of the State Demographer.

Notes - 2009

All mortality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Denominator data provided by the Office of the State Demographer.

Notes - 2008

All mortality data reported for 2008 is final. This indicator has been adjusted for final data.

Denominator data provided by the Office of the State Demographer.

Narrative:

The mortality rate of unintentional injuries among children aged 14 years and younger as a result of motor vehicle crashes declined to 4.4 deaths per 100,000 children aged 14 years and younger in 2009. The unintentional injury mortality rate for children 14 years and younger has showed a steady decline since 2006. In 2005, fatalities due to motor vehicle crashes accounted for nearly half (45.3%) of all unintentional deaths in Texas. Projections for 2009 indicate that motor vehicle crashes accounted for 49.6% of all unintentional deaths.

//2012/ The mortality rate of unintentional injuries among children aged 14 years and younger as a result of motor vehicle crashes declined to a low of 3.5 deaths per 100,000 children aged 14 years and younger in 2008; however, an increase in the rate was observed between 2008 and 2010. In 2006, fatalities due to motor vehicle crashes accounted for nearly half (52.7%) of all unintentional deaths in Texas. Projections for 2010 indicate that motor vehicle crashes accounted for 42.9% of all unintentional deaths. //2012//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	27.7	26.0	25.3	22.0	23.5
Numerator	1000	953	937	825	871
Denominator	3610691	3658558	3703880	3751857	3704504
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 - 2010

All mortality data reported for 2010 is estimated. Estimates are based on a linear trend of data from 1999 through 2008.

Denominator data projected by the Office of the State Demographer.

Notes - 2009

All mortality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Denominator data provided by the Office of the State Demographer.

Notes - 2008

All mortality data reported for 2008 is final. This indicator has been adjusted for final data.

Denominator data provided by the Office of the State Demographer.

Narrative:

The fatality rate from unintentional injuries due to motor vehicle crashes per 100,000 youth aged 15 to 24 years has ranged from a high of 27.7 fatalities per 100,000 youth aged 15 to 24 years in 2006 to a low of 25.5 fatalities per 100,000 youth aged 15 to 24 years in 2008 and 2009 (projected).

/2012/ The fatality rate from unintentional injuries due to motor vehicle crashes per 100,000 youth aged 15 to 24 years has ranged from a high of 27.7 fatalities per 100,000 youth aged 15 to 24 years in 2006 to a low of 22.0 fatalities per 100,000 youth aged 15 to 24 years in 2009. Projections estimate that this rate has increased to 23.5 per 100,000 youth aged 15 to 24 years in 2010, although an overall decrease has been observed between 2006 and 2010 (projected). //2012//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	253.1	260.3	279.8	286.1	319.7
Numerator	13383	13880	15067	15590	16358
Denominator	5287340	5332129	5384151	5449069	5117214
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 - 2010

Numerator data for 2010 is a linear projection using the Texas EMS Trauma Registry data from 2004 through 2009. Denominator data is a 2010 population projection from the Office of the State Demographer.

Notes - 2009

Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. The denominator for this indicator has been adjusted for final data. Data from 2006 through 2009 are final.

Notes - 2008

Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. Data from 2006 through 2009 are final.

Narrative:

From 2005 through 2007, there were approximately 13,000 nonfatal injuries among children aged 14 years and younger. This number increased to approximately 15,000 in 2008 and 2009. For 2009, the ratio of nonfatal to fatal unintentional injuries was 32.3:1. The ratio for 2008 was 30.4:1 indicating that there has been a decrease in the number of fatal injuries compared to the number of nonfatal injuries. Information gathered from local child fatality review teams may be used to develop interventions to reduce the number of injuries among children aged 14 years and younger.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	43.8	43.1	42.5	38.7	42.1
Numerator	2318	2296	2286	2109	2152
Denominator	5287340	5332129	5384151	5449069	5117214
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 - 2010

Numerator data for 2010 is a linear projection using the Texas EMS Trauma Registry data from 2004 through 2009. Denominator data is a 2010 population projection from the Office of the State Demographer.

Notes - 2009

Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. The denominator for this indicator has been adjusted for final data. Data from 2006 through 2009 are final.

Notes - 2008

Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. Data from 2006 through 2009 are final.

Narrative:

Since 2005, there have been more than 2,000 nonfatal injuries annually among children aged 14 years and younger. The number of nonfatal injuries decreased steadily between 2005 and 2009, with a high of 2,772 in 2005 to a low of 2,109 in 2009. While motor vehicle crashes accounted for approximately half of all unintentional injury fatalities, in 2009, motor vehicle crashes accounted for 13.5% of all nonfatal injuries.

//2012/ While motor vehicle crashes accounted for approximately half of all unintentional injury fatalities, in 2010, motor vehicle crashes accounted for 13.2% of all nonfatal injuries. //2012//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	177.5	173.7	167.8	155.8	166.3
Numerator	6408	6356	6216	5846	6159
Denominator	3610691	3658558	3703880	3751857	3704504
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 - 2010

Numerator data for 2010 is a linear projection using the Texas EMS Trauma Registry data from 2004 through 2009. Denominator data is a 2010 population projection from the Office of the State Demographer.

Notes - 2009

Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. The denominator for this indicator has been adjusted for final data. Data from 2006 through 2009 are final.

Notes - 2008

Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. Data from 2006 through 2009 are final.

Narrative:

Since 2005, there have been approximately 6,000 nonfatal injuries annually among children aged 15 through 24 years. The number of nonfatal injuries decreased between 2005 and 2009, with a high of 6,408 in 2006 to a low of 5,846 in 2009. In 2009, the ratio of nonfatal unintentional injuries due to motor vehicle crashes among youth 15 to 24 years of age and 14 years of age or under is 6.2:1. The 2008 national rate (latest year available on CDC WISQARS) of nonfatal unintentional injuries due to motor crashes among youth 15 to 24 years of age (174.7 nonfatal injuries per 10,000 population) was 4.1 percent higher than the Texas rate in 2008 (167.8 nonfatal injuries per 10,000 population).

//2012/ The number of nonfatal injuries decreased between 2006 and 2009, however, projected estimates show a slight increase from 155.8 per 100,000 youth aged 15 through 24 years in 2009 to 166.3 per 100,000 in 2010. //2012//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	25.6	27.8	31.8	33.1	37.6
Numerator	22583	24946	28928	30350	33296
Denominator	880975	895967	908436	916799	884745
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 - 2010

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.

Notes - 2009

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the Office of the State Demographer. Denominator data has been adjusted for final population estimates.

Notes - 2008

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the Office of the State Demographer.

Narrative:

The rate of Chlamydia among women 15 to 19 years of age in Texas increased in 2007, 2008, and 2009. The rate of 34.0 cases per 1,000 women 15 to 19 years is a 31.8% increase over the rate in 2005. The Chlamydia rate has been over 30 for the past two years. The Chlamydia rates for Texas women 15 to 19 years of age were similar to the US rates. The Texas rate was lower than the US rate in 2005, 2006, and 2007. The Texas rate (32.7 cases per 1,000 women) was higher than the US rate (32.6 cases per 1,000 women) in 2008 (latest year available for the US). Increased collaboration between the Texas TB/HIV/STD Unit and the Texas Family Planning Program may help to turn the direction of this trend. A program to increase Chlamydia testing and diagnosis in family planning clinics has demonstrated early success.

//2012/ The rate of 37.6 cases per 1,000 women 15 to 19 years in 2010 is a 36.6% increase over the rate in 2006. The Chlamydia rate has been over 30 for the past three years. The Chlamydia rates for Texas women 15 to 19 years of age were similar to the US rates. The Texas rate was lower than the US rate in 2008. The Texas rate (33.1 cases per 1,000 women) was only slightly lower than the US rate (33.3 cases per 1,000 women) in 2009 (latest year available for the US). The gap between the Texas rate and the US rate has decreased each year between 2006 and 2009. //2012//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	8.5	9.4	10.7	11.0	12.4
Numerator	36124	40635	46526	48639	56576
Denominator	4263884	4310753	4366483	4430565	4571960
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 - 2010

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.

Notes - 2009

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the Office of the State Demographer. Denominator data has been adjusted for final population estimates.

Notes - 2008

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the Office of the State Demographer.

Narrative:

The rate of Chlamydia among women 20 to 44 years of age increased each year from 2005 through 2009. The rate of 11.0 cases per 1,000 women 20 to 44 years is more than double the

rate in 1996. The Chlamydia rate has been over 10.0 for the past two years. The Chlamydia rates for Texas women 20 to 39 years of age were similar to the US rates. The CDC interactive STD data website (<http://wonder.cdc.gov/std-std-v2008-race-age.html>) does not allow the user to break out the 20 to 44 year old age category. The Texas rate was lower than the US rate in 2005 and 2006. The rates were the same for 2007. The Texas rate (12.8 cases per 1,000 women) was lower than the US rate (13.8 cases per 1,000 women) in 2008 (latest year available for the US). Increased collaboration between the Texas TB/HIV/STD Unit and the Texas Family Planning Program may help to turn the direction of this trend. A program to increase Chlamydia testing and diagnosis in family planning clinics has demonstrated early success.

/2012/ The rate of Chlamydia among women 20 to 44 years of age increased each year from 2006 through 2010. The rate of 12.4 cases per 1,000 women 20 to 44 years is more than double the rate in 1996. The Chlamydia rate has been over 10.0 for the past three years. The Chlamydia rates for Texas women 20 to 39 years of age were similar to the US rates for 2006 to 2008. //2012//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY	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
TOTAL POPULATION BY RACE								
Infants 0 to 1	405471	345043	44678	0	0	0	0	15750
Children 1 through 4	1581862	1345250	175881	0	0	0	0	60731
Children 5 through 9	1862632	1580364	213816	0	0	0	0	68452
Children 10 through 14	1672720	1391614	221755	0	0	0	0	59351
Children 15 through 19	1810902	1487723	252661	0	0	0	0	70518
Children 20 through 24	1893602	1562230	254251	0	0	0	0	77121
Children 0 through 24	9227189	7712224	1163042	0	0	0	0	351923

Notes - 2012

Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.

Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.

Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.

Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.

Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.

Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.

Narrative:

Approximately 96% of all children in Texas are either White or African American. The number of White children may be over-reported due to how race/ethnic data are collected in Texas. In Texas, race and ethnicity are often not asked separately. When collecting data, a common standard is to propose four racial/ethnic categories (White, African American, Hispanic, and Other). This differs from the methodology implemented by the US Census. This presents a challenge when completing federal reporting requirements that solicit information separately for race and ethnicity. To address this barrier, children who have indicated that they are Hispanic using the four race/ethnic categorizations are included with the children that selected White. This is the only available solution that still allows the total of all children by race to equal the total number of all children by ethnicity.

//2012/ Approximately 96.2% of all children in Texas are either White or African American. //2012//

Texas has one of the youngest populations in the United States. Over a third (37.0%) of the Texas population is under the age of 25 years old.

//2012/ Over a third (36.4%) of the Texas population is under the age of 25 years old. //2012//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
TOTAL POPULATION BY HISPANIC ETHNICITY			
Infants 0 to 1	192277	213194	0
Children 1 through 4	773390	808472	0
Children 5 through 9	974115	888517	0
Children 10 through 14	935915	736805	0
Children 15 through 19	1029080	781822	0
Children 20 through 24	1086324	807278	0
Children 0 through 24	4991101	4236088	0

Notes - 2012

Narrative:

A greater proportion of children of Hispanic origin are younger than children of non-Hispanic origin. When comparing children of Hispanic origin to children of non-Hispanic origins by age, the number of children of Hispanic origin in the 0 to 1 year of age group is 30.4% higher than the number of children of non-Hispanic origin. Children of non-Hispanic origin outnumber children of Hispanic origin in all other age groups except infants 0 to 1 and 1 to 4 years of age where the groups are relatively similar. The difference in the 0 to 1 year of age group signals the changing population dynamic that Texas will experience over the next decade.

//2012/ Nearly half (46.0%) of the Texas population under the age of 25 is of Hispanic origin. //2012//

Health Status Indicators 07A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

HSI #07A - Demographics (Total live births)

CATEGORY	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
Total live births								
Women < 15	841	687	146	0	0	0	0	8
Women 15 through 17	18934	16246	2476	0	0	0	0	212
Women 18 through 19	35315	29721	5216	0	0	0	0	378
Women 20 through 34	302781	255043	33735	0	0	0	0	14003
Women 35 or older	47366	39127	4257	0	0	0	0	3982
Women of all ages	405237	340824	45830	0	0	0	0	18583

Notes - 2012

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Narrative:

Maternal age was younger among African American women than White women. Approximately 17% of births among African American women were to women under the age of 20 years compared to 13.5% among White women. Births among White women may be over-reported due to how race/ethnic data are collected in Texas. In Texas, race and ethnicity are often not asked separately. When collecting data, often four racial/ethnic categories (White, African American, Hispanic, and Other) are presented. This differs from the methodology implemented by the US Census. This presents a challenge when completing federal reporting requirements that solicit information separately for race and ethnicity. To address this barrier, children who have indicated that they are Hispanic using the four race/ethnic categorizations are included with the children that selected White. This is the only available solution that still allows the total of all births by race to equal the total number of all births by ethnicity.

//2012/ Approximately 17.1% of births among African American women were to women under the age of 20 years compared to 13.7% among White women. //2012//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Total live births			
Women < 15	220	621	0
Women 15 through 17	5763	13171	0
Women 18 through 19	14306	21009	0
Women 20 through 34	154919	147862	0
Women 35 or older	27204	20162	0
Women of all ages	202412	202825	0

Notes - 2012

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Narrative:

Maternal age was younger among Hispanic women than non-Hispanic women. Approximately 17% of births among Hispanic women were to women under the age of 20 years compared to 10.2% among non-Hispanic women. Approximately three-quarters of all births occur to women ages 20 to 34 years (75.1%). One significant difference is in births to women 15 to 17 years of age. For Hispanic women, 6.2% of all births are accounted for by this age group compared to 3.1% among non-Hispanic women. A similar pattern is found among women 18 to 19 years of age. For Hispanic women, 10.3% of all births are accounted for by women 18 to 19 years of age compared to 7.0% among non-Hispanic women. This translates into birth rates among Hispanic women 15 to 19 years of age that are more than double those of non-Hispanic women. These numbers underscore the need for targeted adolescent pregnancy prevention efforts toward Hispanic adolescents. Texas has hosted a Hispanic Teen Pregnancy Prevention Summit that provided insight into the development of initiatives that could address this disparity in adolescent births.

//2012/ For the first time, the number of births among Hispanic women surpassed the number of births among non-Hispanic women. Approximately 17.2% of births among Hispanic women were to women under the age of 20 years compared to 10.0% among non-Hispanic women. Most births occur to women between ages 20 to 34 years, for both Hispanic and non-Hispanic women. One significant difference continues to be Hispanic women 15 to 17 years of age, with 6.5% of all births accounted for by this age group compared to 2.8% among non-Hispanic women. The similar pattern continues among Hispanic women 18 to 19 years of age with 10.4% of all births are accounted for by this age group compared to 7.1% among non-Hispanic women. //2012//

Health Status Indicators 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	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	2530	1941	461	0	0	0	0	128
Children 1 through 4	521	417	79	0	0	0	0	25
Children 5 through 9	237	194	34	0	0	0	0	9
Children 10 through 14	275	225	36	0	0	0	0	14
Children 15 through 19	1118	963	117	0	0	0	0	38
Children 20	1824	1548	208	0	0	0	0	68

through 24								
Children 0 through 24	6505	5288	935	0	0	0	0	282

Notes - 2012

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Narrative:

Examining just the number of deaths reveals that there are more deaths among White children at all age groups. However, a study of the rates of death provides different information. The gap in child death rates between African American and White children ranges from 151.0% higher in the 0 to 1 year old age group to 5.0% higher in the 15 to 19 year old age group. On average, rates among African American children are 69.3% higher than rates among White children. Increased efforts to address child safety and injury prevention are needed. In the age group with the largest disparity, 0 to 1 year of age, efforts to promote safe infant sleep, especially among the family involved with child protective services may address this gap. The work of local child fatality review teams should also help to reduce these disparities.

Deaths among White children may be over-reported due to how race/ethnic data are collected in Texas. In Texas, race and ethnicity are often not asked separately. When collecting data, often

four racial/ethnic categories (White, African American, Hispanic, and Other) are presented. This differs from the methodology implemented by the US Census. This presents a challenge when completing federal reporting requirements that solicit information separately for race and ethnicity. To address this barrier, children who have indicated that they are Hispanic using the four race/ethnic categorizations are included with the children that selected White. This is the only available solution that still allows the total of all children by race to equal the total number of all children by ethnicity.

/2012/ Child death rates for African American children under the age of 15 exceed the death rate for White children of the same age. The gap in child death rates between African American and White children ranges from 83.4% higher in the 0 to 1 year old age group to 0.4% higher in the 10 to 14 year old age group. White youth aged 15 through 24 have higher death rates than African American youth of the same age. //2012//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Total deaths			
Infants 0 to 1	1419	1111	0
Children 1 through 4	303	218	0
Children 5 through 9	141	96	0
Children 10 through 14	176	99	0
Children 15 through 19	739	379	0
Children 20 through 24	1251	573	0
Children 0 through 24	4029	2476	0

Notes - 2012

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.

Narrative:

The gap in child death rates between Hispanic and non-Hispanic children ranges from 136.5% higher in the 20 to 24 year old age group to 16.7% higher in the 1 to 4 year old age group. On average, rates among Hispanic children are 7.34% higher than rates among non-Hispanic children.

//2012/ Overall the death rate for non-Hispanic children and youth under age 25 was higher than the death rate for Hispanic children and youth of the same age. The gap in child death rates between Hispanic and non-Hispanic children ranges from 38.4% in the 20 to 24 year old age group to 25.4% in the 5 to 9 year old age group. Death rates for non-Hispanic children exceed the death rates for Hispanic children in all age groups. //2012//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc 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	7333587	6149994	908791	0	0	0	0	274802	2010
Percent in household headed by single parent	35.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Number enrolled in Medicaid	2609815	2054999	417996	8261	34674	0	0	93885	2010
Number enrolled in SCHIP	522696	209646	29139	921	11359	0	0	271631	2010
Number living in foster home care	17027	11487	5174	45	58	0	0	263	2010
Number enrolled in food stamp program	2041195	1557915	422105	8157	26509	0	0	26509	2010
Number enrolled in WIC	1317590	1131316	150634	757	13346	1136	20383	18	2010
Rate (per 100,000) of juvenile crime arrests	2397.0	2123.9	4847.0	0.0	0.0	0.0	0.0	532.3	2010
Percentage of high school drop- outs (grade 9 through 12)	2.9	1.3	4.4	2.2	1.0	0.0	0.0	0.0	2009

Notes - 2012

2010 Population Projections provided by the Office of the State Demographer. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Annie E. Casey Foundation's KIDS COUNT 2010 Data Book Online (<http://datacenter.kidscount.org/databook/2010/Default.aspx>). Data are from 2009. Data are not available by race/ethnicity.

Source: Annie E. Casey Foundation's Texas Kids Count. <http://datacenter.kidscount.org/DataBook/2010/StateProfiles.aspx>
Data are for 2009 and are based on children 0-17 years of age. Data are not available by race/ethnicity.

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2010. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages less than 19.

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2010. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages less than 19.

Source: Texas Food Stamp Client Profile, Strategic Decision Support, Health and Human Services Commission, Texas, 2010. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages 0-19.

These data are reported through certification data provided by the WIC program. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

Source: 2010 Juvenile Crime Data report provided by the Texas Department of Public Safety. Maggie Walker, Statistician, Uniform Crime Reporting, maggie.walker@txdps.state.tx.us. Data are reported for children aged 0-17.

Rates for this measure were calculated incorrectly for prior years. Data for 2010 are not comparable to previous years. Due to limitations in the reporting of the data, the total White population (denominator) includes all Hispanic people regardless of race. As a result, the white rate is slightly underestimated and the black rate is slightly overestimated. In 2009, the White denominator was limited to the number of White, Non-Hispanics, leading to an extreme overestimate of the White rate. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Texas Education Agency (http://www.tea.state.tx.us/acctres/dropcomp_index.html, annual dropout rates). Data are from the 2008-2009 academic year.

Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

Source: Foster care data provided by the Texas Department of Family and Protective Services. Available from 2010 DFPS Annual Report and Data Book.

http://www.dfps.state.tx.us/About/Data_Books_and_Annual_Reports/2010/default.asp

Narrative:

White children accounted for 83.8% of the total child population in Texas. This figure may be over-reported due to how race/ethnic data are collected in Texas. In Texas, race and ethnicity are often not asked separately. When collecting data, often four racial/ethnic categories (White, African American, Hispanic, and Other) are presented. This differs from the methodology implemented by the US Census. This presents a challenge when completing federal reporting requirements that solicit information separately for race and ethnicity. To address this barrier, children who have indicated that they are Hispanic using the four race/ethnic categorizations are included with the children that selected White. This is the only available solution that still allows the total of all children by race to equal the total number of all children by ethnicity.

//2012/ White children accounted for 83.9% of the total child population in Texas. //2012//

African American children account for 12.5% of the Texas population, but this figure may be under-represented as children who are African American and Hispanic are misclassified with the White group. While 12.5% of the entire population, African American children were overrepresented in several public aid programs. Sixty-one percent of African American children were enrolled in Medicaid compared to 40% of White children. The proportion of African American children enrolled in the food stamp program (74.3%) was nearly double that of White children (40.2%). Enrollment in WIC was similar between these groups. These data indicate a need for increased targeting and cultural tailoring for interventions for African American children.

//2012/ African American children account for 12.4% of the Texas population, but this figure may be under-represented as children who are African American and Hispanic are misclassified with the White group. While 12.4% of the entire population, African American children were overrepresented in several public aid programs. Forty-six percent of African American children were enrolled in Medicaid compared to 33.4% of White children. The proportion of African American children enrolled in the food stamp program (46.4%) was nearly double that of White children (25.3%). //2012//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
Miscellaneous Data BY HISPANIC ETHNICITY				
All children 0 through 19	3904777	3428810	0	2010
Percent in household headed by single parent	0.0	0.0	35.0	2009
Percent in TANF (Grant) families	0.0	0.0	1.4	2009
Number enrolled in Medicaid	1006869	1602946	0	2010
Number enrolled in SCHIP	365748	156948	0	2010
Number living in foster home care	10548	6479	0	2010
Number enrolled in food stamp program	927816	1111340	0	2010
Number enrolled in WIC	364712	952878	0	2010

Rate (per 100,000) of juvenile crime arrests	2387.3	2407.9	0.0	2010
Percentage of high school drop-outs (grade 9 through 12)	0.0	3.8	0.0	2009

Notes - 2012

Source: 2010 Population Projections provided by the Office of the State Demographer.

Source: Annie E. Casey Foundation's KIDS COUNT 2010 Data Book Online (<http://datacenter.kidscount.org/databook/2010/Default.aspx>). Data are from 2009. Data are not available by race/ethnicity.

Source: Annie E. Casey Foundation's KIDS COUNT 2010 Data Book Online (<http://datacenter.kidscount.org/databook/2010/Default.aspx>). Data are from 2009. Data are not available by race/ethnicity.

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2010.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages less than 19.

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2010.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages less than 19.

Source: Texas Food Stamp Client Profile, Strategic Decision Support, Health and Human Services Commission, Texas, 2010.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages 0-19.

These data are reported through certification data provided by the WIC program.

Source: 2010 Juvenile Crime Data report provided by the Texas Department of Public Safety. Maggie Walker, Statistician, Uniform Crime Reporting, maggie.walker@txdps.state.tx.us. Data are reported for children aged 0-17.

Source: Texas Education Agency (http://www.tea.state.tx.us/acctres/dropcomp_index.html, annual dropout rates). Data are from the 2008-2009 academic year.

Source: Foster care data provided by the Texas Department of Family and Protective Services. Available from 2010 DFPS Annual Report and Data Book. http://www.dfps.state.tx.us/About/Data_Books_and_Annual_Reports/2010/default.asp

Narrative:

Texas has the third largest Hispanic population in the 0 to 19 years age group and is one of only four states in which Hispanics account for more than 40% of this age group. By 2015, children of Hispanic origins will account for a greater proportion of the Texas population than children of non-Hispanic origin. This shift in population may place an increased burden on the Texas health care infrastructure. As the data presented for HIS #09B indicate, the proportion of children of Hispanic origin enrolled in Medicaid (52.3%), enrolled in the food stamp program (52.5%), enrolled in WIC (27.8%) exceed the proportions of children not of Hispanic origin enrolled in these programs

(36.2%, 36.7%, and 8.7%, respectively).

/2012/ Texas has the third largest Hispanic population in the 0 to 17 years age group. As the data presented for HIS #09B indicate, the proportion of children of Hispanic origin enrolled in Medicaid (46.7%), enrolled in the food stamp program (32.4%), enrolled in WIC (27.8%) exceed the proportions of children not of Hispanic origin enrolled in these programs (25.8%, 23.8%, and 9.3%, respectively). //2012//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	6482270
Living in urban areas	6793375
Living in rural areas	484101
Living in frontier areas	56111
Total - all children 0 through 19	7333587

Notes - 2012

Source: 2010 Population Projections from the Office of the State Demographer.

Source: 2010 Population Projections from the Office of the State Demographer.

Source: 2010 Population Projections from the Office of the State Demographer.

Source: 2010 Population Projections from the Office of the State Demographer.

Narrative:

More than 92% of Texas residents live in urban areas. Texas is home to 6 of the 21 largest cities in the United States. With 7,255,037 children ages 0 to 19 years, Texas has the child population equal to Alabama, Arizona, Alaska, Arkansas, Connecticut, Delaware, and the District of Columbia combined. These data summarize the challenge experienced by Texas having to address a sizable population in urban, rural, and frontier areas.

/2012/ More than 92% of Texas residents under the age of 20 live in urban areas. Texas is home to 6 of the 20 largest cities in the United States. With 7,333,587 children ages 0 to 19 years, Texas has the second largest child population of all U.S. states. It is equal to the child populations of Alabama, Arizona, Alaska, Arkansas, Connecticut, Colorado, Delaware, Hawaii, Idaho and the District of Columbia combined. //2012//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	25373948.0
Percent Below: 50% of poverty	6.8
100% of poverty	16.6
200% of poverty	37.4

Notes - 2012

Total population for 2009 is a projection provided by the Office of the State Demographer.

Data Set: 2007-2009 American Community Survey 3-Year Estimates
Survey: American Community Survey

Data Set: 2007-2009 American Community Survey 3-Year Estimates
Survey: American Community Survey

Data Set: 2007-2009 American Community Survey 3-Year Estimates
Survey: American Community Survey

Narrative:

Texas has one of the highest rates of poverty of any state in the United States. More than one-third of the Texas population is within 200% of poverty. More than 1.7 million people in Texas are within 50% of poverty. More than 4.2 million people in Texas are within 100% of poverty. More than 9.4 million people in Texas are within 200% of poverty.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	7333587.0
Percent Below: 50% of poverty	10.3
100% of poverty	23.8
200% of poverty	48.0

Notes - 2012

Total population for 2009 is a projection provided by the Office of the State Demographer.

Data Source: U.S. Census Bureau, 2007-2009 American Community Survey 3-Year Public-Use Microdata Samples http://factfinder.census.gov/home/en/acs_pums_2009_3yr.html

Data Source: U.S. Census Bureau, 2007-2009 American Community Survey 3-Year Public-Use Microdata Samples http://factfinder.census.gov/home/en/acs_pums_2009_3yr.html

Data Source: U.S. Census Bureau, 2007-2009 American Community Survey 3-Year Public-Use Microdata Samples http://factfinder.census.gov/home/en/acs_pums_2009_3yr.html

Narrative:

Approximately half of all Texas children live within 200% of poverty, which is about 3.3 million children. This is greater than the entire child population of all but three states (California, Illinois, and Florida). One-fifth of all Texas children live within 100% of poverty, which is about 1.5 million children. This is greater than the entire child population of 33 states. About ten percent of all Texas children live within 50% of poverty, which is about 700,000 children. This is greater than the entire child population of 16 states.

/2012/ Approximately half of all Texas children live within 200% of poverty, which is about 3.5 million children.

More than one-fifth of all Texas children live within 100% of poverty, which is about 1.7

million children. This is greater than the entire child population of 37 other states. About ten percent of all Texas children live within 50% of poverty, which is about 750,000 children. This is greater than the entire child population of 17 other states. //2012//

F. Other Program Activities

FAMILY/CONSUMER PARTICIPATION

CSHCN SP actively engages consumers and families in the decision-making process. Community-based contractors receiving funding through CSHCN SP have significant parent or parent/professional leadership and participate in advisory boards, meetings, and work groups. Family members attend and actively participate in quarterly conference calls for the Medical Home Work Group, and family member representatives from several contractors participate in bi-monthly conference calls for the Transition Team. CSHCN SP provides funding for the Leadership Education in Adolescent Health (LEAH) project at Baylor College of Medicine in Houston which enables 50 family members from throughout the state to attend the annual LEAH transition conference. The program has strong ties with Texas Parent to Parent (TxP2P), the federally funded Family-to-Family Health Care Education and Information Center and collaborates with their efforts to educate parents and caregivers. Staff participate in the TxP2P annual conference as speakers, planners, and exhibitors. Staff work with parents and teens to execute the Teen Transition Expo which is part of the TxP2P annual conference. Parents of CYSHCN in various geographic locations have become Family Voices representatives and are key advocates for improving access to and coordination of health and other services for CYSHCN. Regional social work staff and the program's community-based service contractors work to facilitate family access to services, promote family networking, increase family involvement in community service system development decisions, and obtain family feedback.

Consumers and family members receiving services through Title V contracted providers participated in the FY11 Five-Year Needs Assessment process through focus groups, community listening sessions, and surveys, resulting in more direct contact and enhanced response than had been historically achieved through less personal methods. Title V staff participate in a large number of statewide councils and workgroups with family member representation or leadership. DSHS regional staff attend and participate in local or regional meetings and events, which emphasize family member involvement.

2-1-1 TEXAS

Through a public/private collaboration of the United Way and other community-based organizations, HHSC administers 2-1-1 Texas, a toll-free, one-stop telephone resource to receive information and referrals for existing health and social services resources throughout Texas. Calls are routed to one of 25 local agencies contracted to answer calls for a certain geographic area where trained resource specialists ascertain the caller's need and assist them utilizing a comprehensive database listing of health and social services for the local area. In addition, individuals can call 2-1-1 to begin the eligibility determination process for services such as Medicaid, CHIP, and the Supplemental Nutrition Assistance Program. A searchable database of services is available to the public at <https://www.211texas.org/211/search.do>. 2-1-1 has also become an important component in Texas' disaster response. During Hurricane Ike and the recent H1N1 flu outbreak, 2-1-1 Texas quickly and efficiently shared emergency response information to assist people affected. In Texas, calls to the 1-800-311-BABY line for information on maternal and child and health are answered by 2-1-1 resource specialists. In FY09, 2-1-1 Texas handled over 2.4 million calls. Approximately 130,000 of these calls were categorized, according to the taxonomy guidelines, as related to maternal and child health. The top category was for dental care, with more than 14,000 calls.

CHILD FATALITY REVIEW

Title V staff coordinate the work of the State Child Fatality Review Team (SCFRT) Committee, a statutorily-defined multidisciplinary group of professionals who serve to: develop an understanding of the causes and incidences of child deaths in Texas; identify procedures within the agencies represented on the committee to reduce the number of preventable child deaths; and promote public awareness and make recommendations for changes in law, policy, and practice to reduce the number of preventable child deaths. The SCFRT Committee works closely with local child fatality review teams (CFRTs) from across the state. These local CFRTs conduct the actual reviews, provide data on all reviews, and identify local child safety issues. In submitting local data, local teams together create a detailed picture of child death as a public health issue in Texas. The SCFRT Committee reviews the data collected statewide to develop position statements and make recommendations for policy change.

Texas currently has 63 CFR teams that serve 187 counties. There were 506,526 children residing in counties that did not have a CFRT team in 2008 (7.80% of the total population). The remaining 5,988,698 children (92.2%) live in a county that has CFRT coverage.

SAFE SLEEP

The Infant Health Workgroup, comprised of DSHS MCH staff and DFPS staff in the areas of Child Protective Services (CPS) Investigations, Child Care Licensing, and the Division of Prevention and Early Intervention, was recently formed to address activities related to infant health, including safe sleep. A subcommittee of this workgroup developed a community-based training on safe sleep for infants for use by anyone who works with parents -- professionals, paraprofessionals and lay workers. Another subcommittee worked with a social marketing firm to develop a Safe Sleep Environment Assessment training which will be required of all CPS caseworkers.

Title V administers an autopsy reimbursement program mandated by Texas statute that allows counties to claim a fixed reimbursement toward the cost of an autopsy where the cause of death is determined to be Sudden Infant Death Syndrome (SIDS). The program also provides a mechanism to track data related to SIDS deaths to better understand the circumstances surrounding SIDS.

HOME VISITING

HHSC and DSHS leadership have designated the OTV&FH to lead the interagency collaborative process for completing the statewide needs assessment for the Maternal, Infant, and Early Childhood Home Visiting Program as required by the Patient Protection and Affordable Care Act. The home visiting needs assessment interagency workgroup, led by the Title V Director, is currently developing the required home visiting program needs assessment. Upon completion of the needs assessment, the program was transferred to the Office of Program Coordination for Children and Youth at HHSC. DSHS staff continue to support their efforts to fully implement the home visiting program.

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 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	34446314	22090523	34437266		33678798	
2. Unobligated Balance <i>(Line2, Form 2)</i>	12894495	11497250	8580980		9306829	
3. State Funds <i>(Line3, Form 2)</i>	56129051	52724786	54886980		46105185	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	250000	2724464	250000		290902	
6. Program Income <i>(Line6, Form 2)</i>	37706	2662461	2527780		2527780	
7. Subtotal	103757566	91699484	100683006		91909494	
8. Other Federal Funds <i>(Line10, Form 2)</i>	570310569	554949188	605513800		626031673	
9. Total <i>(Line11, Form 2)</i>	674068135	646648672	706196806		717941167	

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

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	8476492	4236601	4776187		3481486	
b. Infants < 1 year old	99777	42704	57725		54268	
c. Children 1 to 22 years old	24268091	19159536	20525721		20081460	

d. Children with Special Healthcare Needs	49669910	48687608	51907849		44833549	
e. Others	14100275	13514063	16545619		17336457	
f. Administration	7143021	6058972	6869905		6122274	
g. SUBTOTAL	103757566	91699484	100683006		91909494	
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	94644		93713		133669	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	554091746		581324119		598926315	
h. AIDS	0		0		0	
i. CDC	8526836		7418165		8589827	
j. Education	0		0		0	
k. Other						
Family Planning X	0		0		17680526	
NHSCPC/Male Involvem	701336		0		701336	
FamPlanning Title X	0		15976467		0	
NHSCPC/MaleInvolve	0		701336		0	
Fam Planning Title X	6896007		0		0	

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

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	79083028	68538384	73074976		68695349	
II. Enabling Services	6339478	5045617	5876806		5057173	
III. Population-Based Services	12076131	9121596	13459743		9142487	
IV. Infrastructure Building Services	6258929	8993887	8271481		9014485	
V. Federal-State Title V Block Grant Partnership Total	103757566	91699484	100683006		91909494	

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//

Forms 3, 4, and 5 show variations in expenditure amounts from previous years, which are best explained by changes in available prenatal care benefits through CHIP and the impact of changes in CHIP and Medicaid eligibility. From December 2008 to December 2009, the numbers of Medicaid eligible children under age 19 grew 13% to 2,458,117. During the same period, Texas saw an 8.5% increase in monthly enrollment in the Children's Health Insurance Program (CHIP) with a steady enrollment in the state's CHIP Perinatal program that began in 2007. While these changes are positive in providing access to needed care, Title V has continued to maintain infrastructure necessary to provide prenatal care and well-child and dental care through existing contracts, primarily acting as a transitional means of obtaining care while completing the eligibility and enrollment process for CHIP or Medicaid.

Form 3

From FY06 to FY09, expenditures decreased from \$87 million to \$85 million even as the federal award was slightly increased in the last year. In addition to the impact of a reduction in direct services sought from Title V, there was a change in the calculation of the indirect rate applied to funding that had a substantial impact increasing available funds. As noted in the last application, the result of retrospectively applying the revised formula to client services contracts from FY07 forward resulted in a net increase in the carryforward amount of approximately \$1 million each year. While expenditures in state funds increased from \$45.8 to \$48.5 million from FY06 to FY09, the growth in carryforward funds continues. Mid-year reviews in direct services contracts have been expanded to identify potential opportunities to invest funds in agency collaborative population-based and infrastructure building projects in FY09, FY10, and FY11.

//2012/ As FY09 expenditures were finalized, the final amount of \$83 million was approximately 3% less than projected in the application submitted last year. Approximately \$1 million in federal funds and \$1.5 million in state funds were not spent. The current estimated expenditures for FY10 are just under \$92 million, however it should be noted that during FY10, state agencies were directed to implement cost containment efforts in response to projected decrease in state revenue. Strategies included implementation of in-state and out-of-state travel restrictions, reduced travel reimbursement allowances, provider reimbursement reductions, and limitations on filling vacant positions. Those strategies continued throughout FY11. It is predicted that this will impact final FY10 and FY11 expenditures. //2012//

Form 4

Data from FY06 thru FY09 indicate that Title V expenditures for the CSHCN population have increased from \$35 to \$42 million during that time period. The significant decrease in the expenditures for pregnant women and infants first seen in the FY10 Application continues with the reduction in expenditures from almost \$16 million in FY06 to just over \$7 million in FY09. As previously noted, the change is tied to the increased availability of alternative sources of direct health care services as noted above. In FY09, an observed increase in expenditures for children 1-22 may be linked to the increased number of children without health insurance as noted in National Performance Measure 13.

//2012/ The expenditures for CSHCN are projected to increase again in FY10 as a result of additional children and youth being served by the agency. The expenditures for pregnant women and infants continue to decrease as a result of greater coverage of direct care services through the CHIP and Medicaid programs. In FY10, the Office of Title V & Family Health continued efforts to identify new opportunities to collaborate with other programs in the agency to build upon existing programs serving mothers, infants, children and youth. Partnerships with programs in the Divisions of Mental Health and Substance Abuse Services, and Prevention and Preparedness Services, led to planned projects that redirected funds from direct care to population-based and infrastructure building efforts. //2012//

Form 5

Within each year, direct services increased in FY08 and FY09 primarily from the increase in CSHCN expenditures; however, there have been slight adjustments in the other three categories of services. FY09 expenditures in Population-Based and Infrastructure Building Services increased as a result of investment in time limited projects focused on utilizing the unobligated funding from the previous period.

//2012/ As noted in Form 5, direct care service expenditures are projected to be nearly 75% of the total expenditures for FY10. It does appear that infrastructure building services are projected to continue to increase from 6% in FY08 to 10% of the total amount in FY10. Time-limited collaborative projects initiated in FY10 will continue in FY11, with the majority in population-based and infrastructure building areas. //2012// An attachment is included in this section. VA - Expenditures

B. Budget

Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort (MOE) amount of \$40,208,728 as required. An additional \$6 million in state funds has been budgeted, in addition to the \$8.5 million carried forward from the FY10 award. Texas continues to exceed the state match rate of \$3 state dollars for every \$4 federal Title V dollars and provides funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

//2012/ The commitment of general revenue for FY12 exceeds the MOE requirement by more than \$5.8 million. The final state budget appropriations in the General Appropriation Act, House Bill 1, 82nd Regular Session are being assessed and the DSHS Operating Budget for FY12 is under development. General revenue reductions in programs that have been included in the budgeted amount for MOE in previous years will be offset by identifying general revenue expenditures in other areas within the agency that serve mothers and infants, children and adolescents, and children with special health care needs. Such general revenue will only include funding that is not being claimed as a match or MOE for any other federal funds. //2012//

30% - 30% Federal Requirement

The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Office of Title V and Family Health requires all MCH Title V-funded contractors to provide child health services in the amount of at least 30% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are

to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on compliance with the 30% - 30% requirement on a monthly basis. The Family and Community Health Services Division and Title V program leadership review reports, provide feedback, and adjust service delivery as needed to maintain the required spending proportions.

For FY11, Form 2 shows that \$10,331,180 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional \$10,331,180 for children with special care needs. The same vigorous monitoring process described above is in place to comply with the 10% cap on administrative expenditures which are budgeted at 3,443,727 in FY11.

//2012/ The procedures described in the application submitted last year remain in place to ensure that expenditure of federal funds meets the 30/30 requirement and that the department does not exceed the administrative cap of 10%. In the FY12 projected budget, \$10,103,639 of the federal Title V funds are earmarked for children and adolescents, with the same amount noted for children and youth with special health care needs. //2012//

Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These grants include, but are not limited to: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - State Early Childhood Comprehensive Systems; 4) Centers for Disease Control and Prevention (CDC) - Breast and Cervical Cancer Early Detection Program; 5) Support State Oral Disease Prevention Program; 6) Texas Cancer Council - regional school health specialists; 7) Title X State Coordinated Family Planning Project; 8) CDC Pregnancy Risk Assessment Monitoring System; 9) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 10) Chronic Disease Prevention and Health promotion- Obesity Component; 11) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement; and 12) CDC - Evidence-Based Laboratory Medicine: Quality/Performance Measure Evaluation; 13) CDC - Texas Early Hearing & Detection & Intervention Tracking, Surveillance & Integration; and 14) ARRA funding and potential funding that may be available through the Affordable Health Care Act.

//2012/ Current status of some funding noted above is unknown as federal awards are pending. In addition to Medicaid and CHIP funding, the following are known to be available to Texas for FY12: 1) MCHB - State Systems Development Initiative; 2) MCHB - State Early Childhood Comprehensive Systems; 3) Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Program 4) Centers for Disease Control and Prevention (CDC) - Breast and Cervical Cancer Early Detection Program; 5) Support State Oral Disease Prevention Program; 6) Title X State Coordinated Family Planning Project; 7) CDC Pregnancy Risk Assessment Monitoring System; 8) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 9) HRSA Cooperative Agreement for Primary Care; and 10) CDC - Texas Early Hearing & Detection & Intervention Tracking, Surveillance & Integration; and 11) ARRA funding related to breastfeeding promotion and promotion of National Health Service Corps available through the Affordable Health Care Act. //2012//

VI. Reporting Forms-General Information

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

VII. Performance and Outcome Measure Detail Sheets

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

VIII. Glossary

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

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

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

C. Organizational Charts and All Other State Supporting Documents

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

D. Annual Report Data

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



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, 2011

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 2012. 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 Cooper, Director, Office of Title V and Family Health at 512-458-7111, extension 2184, or me at 512-458-7321. Thank you for your consideration and review of the Texas Maternal and Child Health Services Title V Block Grant Application for FY12 and Annual Report for FY10.

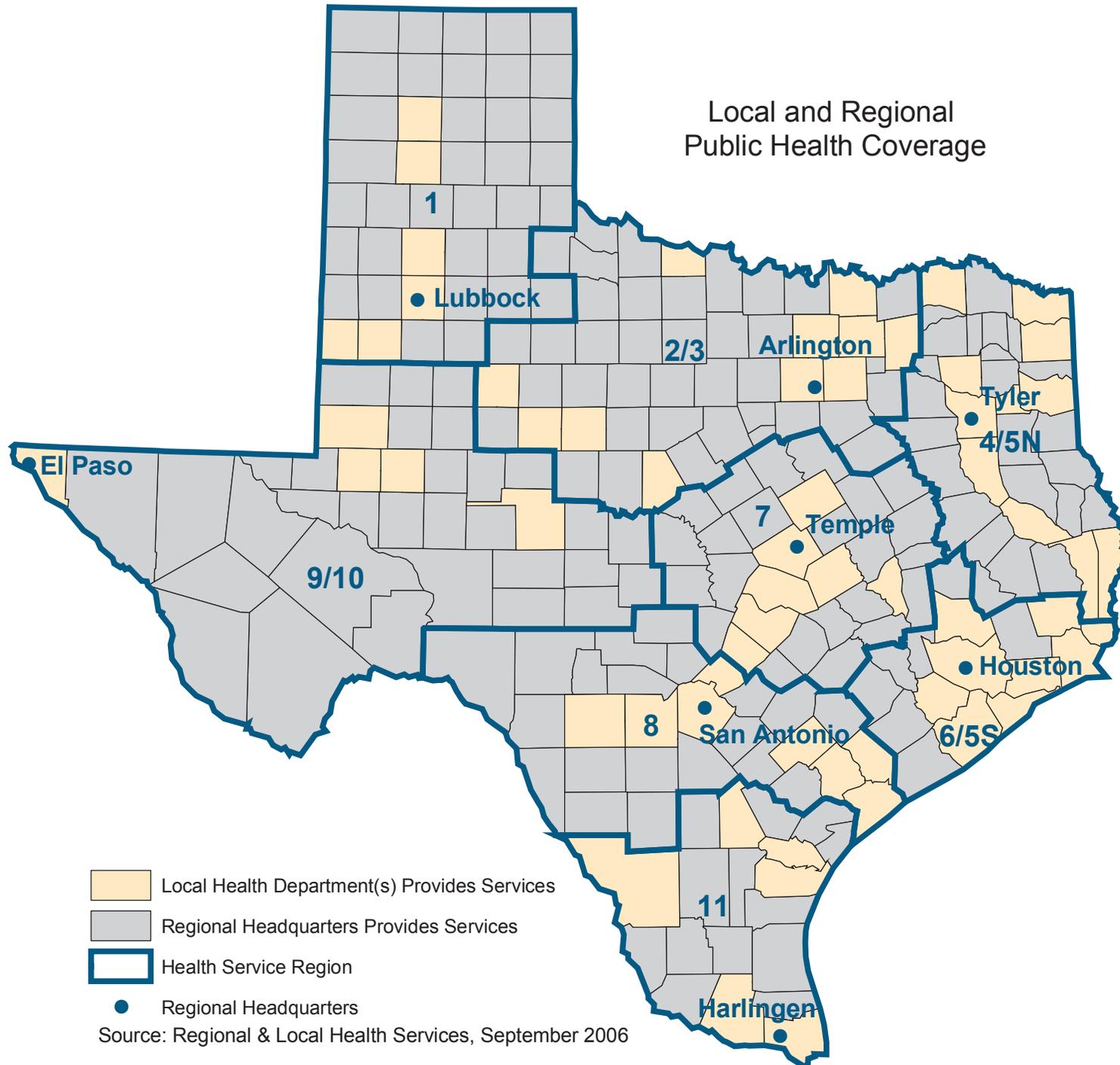
Sincerely,

A handwritten signature in black ink that reads "Evelyn Delgado".

Evelyn Delgado, Assistant Commissioner
Family and Community Health Services

Attachment

An Equal Opportunity Employer and Provider



**82nd Texas Legislative Sessions Summary
Selected Bills Relating to Maternal and Child Health
January – June 2011**

The 82nd Legislature, Regular Session ended on May 30, 2011. The First Called Session ended June 30, 2011. The following table includes a brief overview of key legislation impacting maternal and child health in Texas. (prepared on 6/30/2011)

Children and Youth with Special Health Care Needs
<p><u>HB 1481</u> - Establishes the definition of "intellectual disability" in the Texas Health and Safety Code, requires the Sunset Advisory Commission to consider respectful language in their bill recommendations, requires health and human services agencies to use respectful language in all reference materials, publications, and electronic materials, publications, and electronic media, and requires that the new language be used when referencing persons with mental retardation.</p>
Prevention of Child Abuse and Neglect
<p><u>SB 434</u> – Establishes a task force to examine the relationship between family violence and child abuse and neglect; develop policy recommendations, if needed, to address issues and effects resulting from that relationship; and develop comprehensive statewide best practices guidelines for both child protective services and family violence shelter centers.</p> <p><u>SB 1154</u> - Creates a nine-member task force to establish a revised strategic plan for reducing child abuse and neglect and improving child welfare. The bill requires the task force to identify all existing programs in Texas relating to reducing child abuse and neglect or improving child welfare and, of the programs identified, those programs that receive state money.</p>
Child Safety
<p><u>HB 673</u> – Requires the Texas Parks and Wildlife Department to produce a recreational water safety video suitable for high school students that includes instruction on safe participation in recreational activities in, on, or around the lakes, rivers, and coastal waters of Texas.</p> <p><u>HB 675</u> - Prohibits a school district from using football helmets that are 16 years old or older and requires helmets older than 10 years to be reconditioned at least every 2 years. Districts will be required to keep documents proving the date a helmet was purchased and anytime a helmet is reconditioned.</p> <p><u>HB 1942</u> - Seeks to prevent bullying in schools by updating the definition of bullying to include that through electronic means (cyberbullying), providing for the transfer of the student who engages in bullying, allowing staff development to include training on preventing, identifying, responding to, and reporting incidents of bullying and mandating that each board of trustees of each school district adopt a policy, including</p>

any necessary procedures, to address the prevention, investigation, and reporting of incidents of bullying.
Immunizations
Medicaid
<u>SB 293</u> - Requires the Health and Human Services Commission (HHSC) to create a system for reimbursing Medicaid providers for telehealth and home telemonitoring services if cost-effective and to report on Medicaid telehealth and home telemonitoring services biannually.
Physical Activity, Nutrition, and Obesity
Coordination of Health and Human Services
<u>SB 717</u> - Expands the purposes for which the Council on Children and Families is established to include the promotion of the sharing of information regarding children and their families among state agencies. The bill expands the council's required duties to include the identification of technological methods to ensure the efficient and timely transfer of information among state agencies providing health, education, and human services to children and their families.
Access to Care
<u>SB 189</u> - Requires an applicant for a license to practice medicine who is not a United States citizen or an alien lawfully admitted for permanent residence in the United States to practice medicine or sign an agreement to practice medicine for at least three years in an area in Texas that is designated by the U.S. Department of Health and Human Services as a health professional shortage area or a medically underserved area.
<u>HB 2610</u> - Seeks to improve the efficiency and maximize the effectiveness of TIERS by establishing a statewide community-based navigator program to assist individuals applying for certain public assistance benefits online through TIERS or any other electronic eligibility system. Additionally, the bill requires DSHS to study the feasibility of employing community health workers to provide health care services and to explore methods of finance or reimbursement to support the provision of such services.
Health Information
<u>HB 824</u> - Seeks to increase a father's participation in the prenatal period of his child's life by requiring the Texas Attorney General to develop a publication describing the importance of a father's role during pregnancy for distribution to contractors and clients of the DSHS Women, Infants, and Children program.
<u>HB 3336</u> – Amends current law relating to information required to be provided to parents of a newborn by hospitals and birthing centers to include information on pertussis disease, vaccine availability, and CDC recommendations for caregiver vaccination.
Infant Mortality
<u>HB 1983</u> - Requires HHSC to develop evidence-based quality initiatives and implement

cost-cutting measures designed to reduce the number of elective or nonmedically indicated induced deliveries or cesarean sections performed at a hospital on a Medicaid recipient before the 39th week of gestation and to study the effectiveness of implemented initiatives.

HB 2636 – Requires HHSC to create the Neonatal Intensive Care Unit Council to study and make recommendations regarding a neonatal intensive care unit's operating standards, Medicaid reimbursement for services provided to an infant admitted to a neonatal intensive care unit, and best practices and protocols to lower admissions to neonatal intensive care units.

State Laboratories

SB 80 – Requires DSHS to adopt and implement the recommendations developed by the state auditor’s office review and to submit a report to the legislature on the department’s progress under these provisions by not later than September 1, 2012.

Child Care

SB 260 – Increases from 8 to 24 the hours of initial training required of certain employees of a day care center. The bill specifies that such training must be completed no later than the 90th day after the employee's first day of employment and also makes the requirement applicable to an employee who has less than two years of employment experience in a regulated child care facility. The bill also increases from 15 to 24 the hours of annual training required for each employee of a day care center or group day care home, and increases from 20 to 30 the hours of required annual training for each director of a day care center or group day care home.

SB 264 - Requires each local workforce development board, not later than January 1, 2012, to provide information on quality child-care indicators for each licensed or registered child-care provider in the area and to determine the manner in which to provide such information.

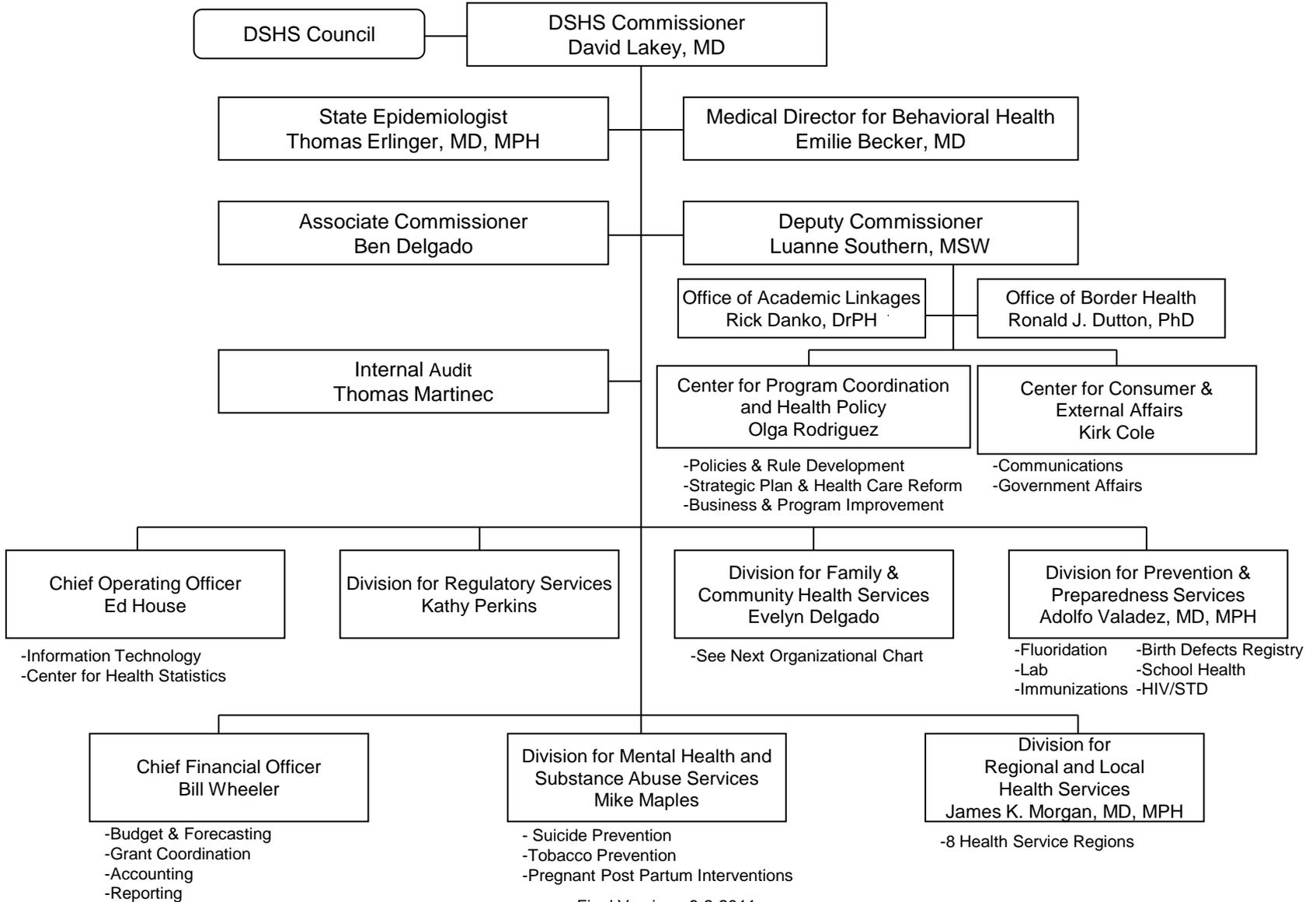
SB 265 – Requires mandated training for certain facilities, homes, and agencies that provide child care services to be appropriately targeted and relevant to the age of the children who will receive care from the individual receiving training. Moreover, the bill requires such training to be provided by a person who meets a set of standard criteria.

Health Disparities

SB 501 – Incorporates the duties of the former Office of Elimination of Health Disparities into a new Center for Elimination of Disproportionality and Disparities. The bill requires the development of a new Interagency Council for Addressing Disproportionality, including representatives from all five HHS agencies as well as the Texas Education Agency, Texas Youth Commission, Texas Juvenile Probation Commission, Attorney General’s Office, Criminal Justice Division of the Governor’s Office, Office of Court Administration of the Texas Judicial System, and the Permanent Judicial Commission for Children, Youth, and Families.

Texas Department of State Health Services

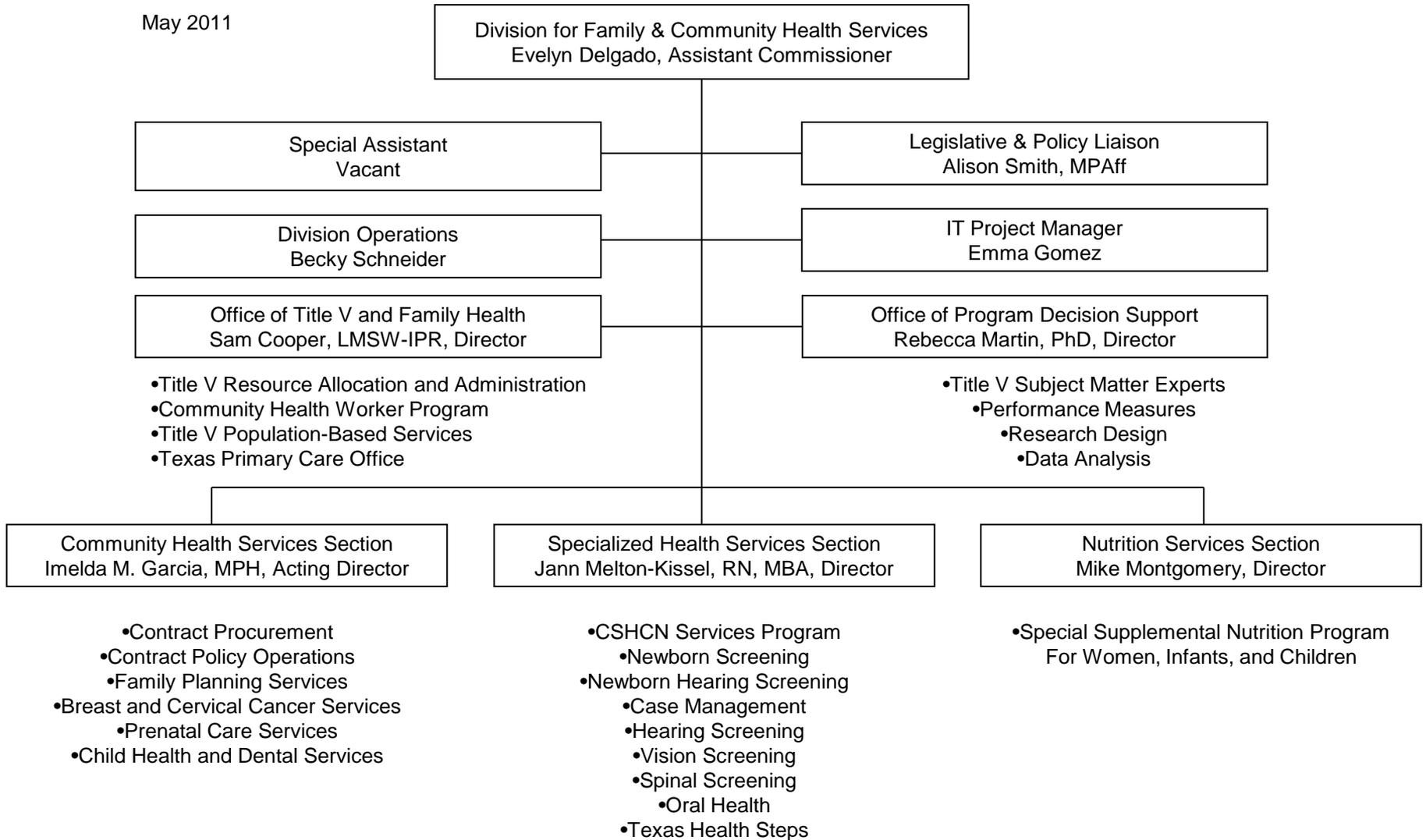
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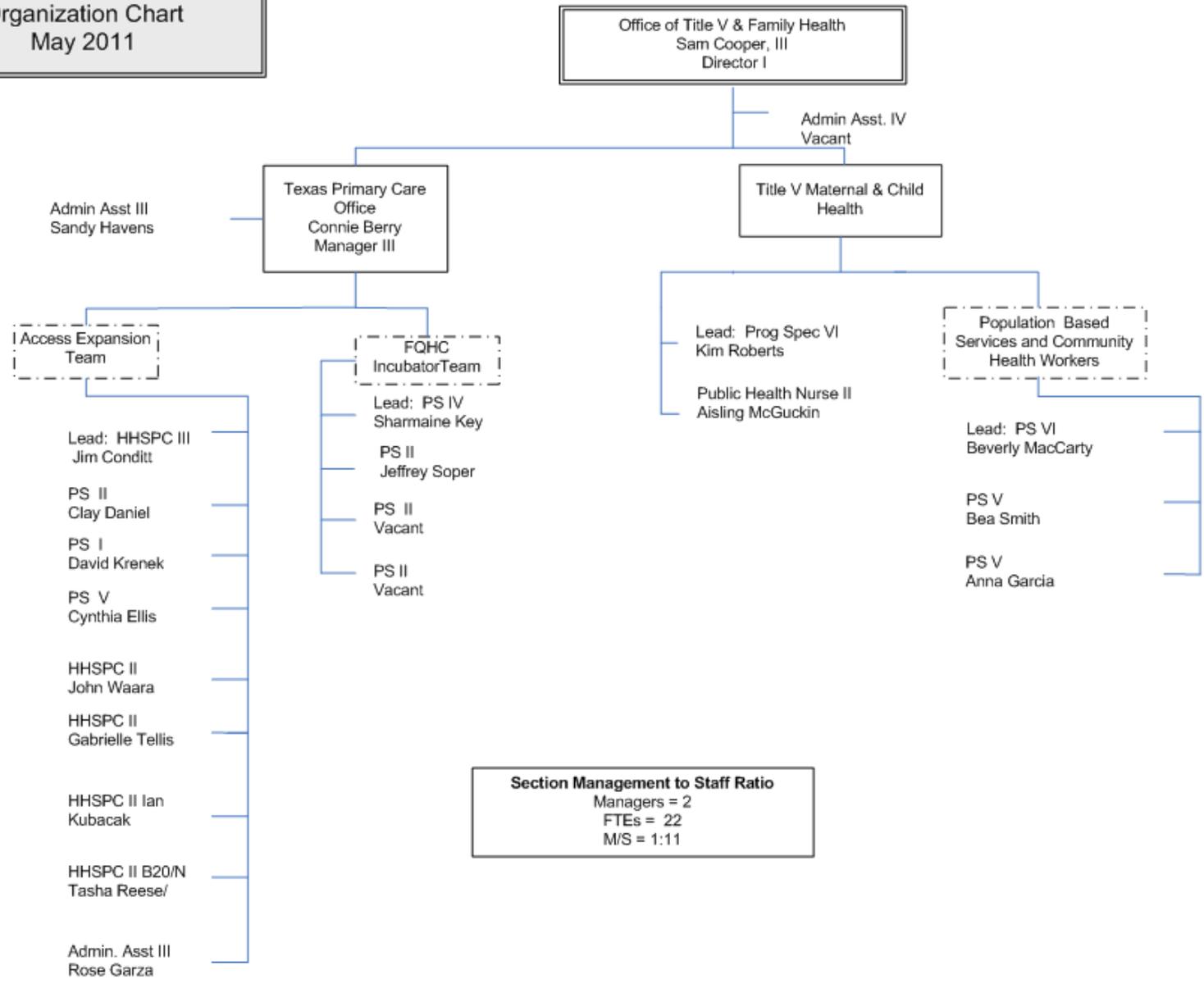
Division for Family & Community Health Services

Title V Support and Resources

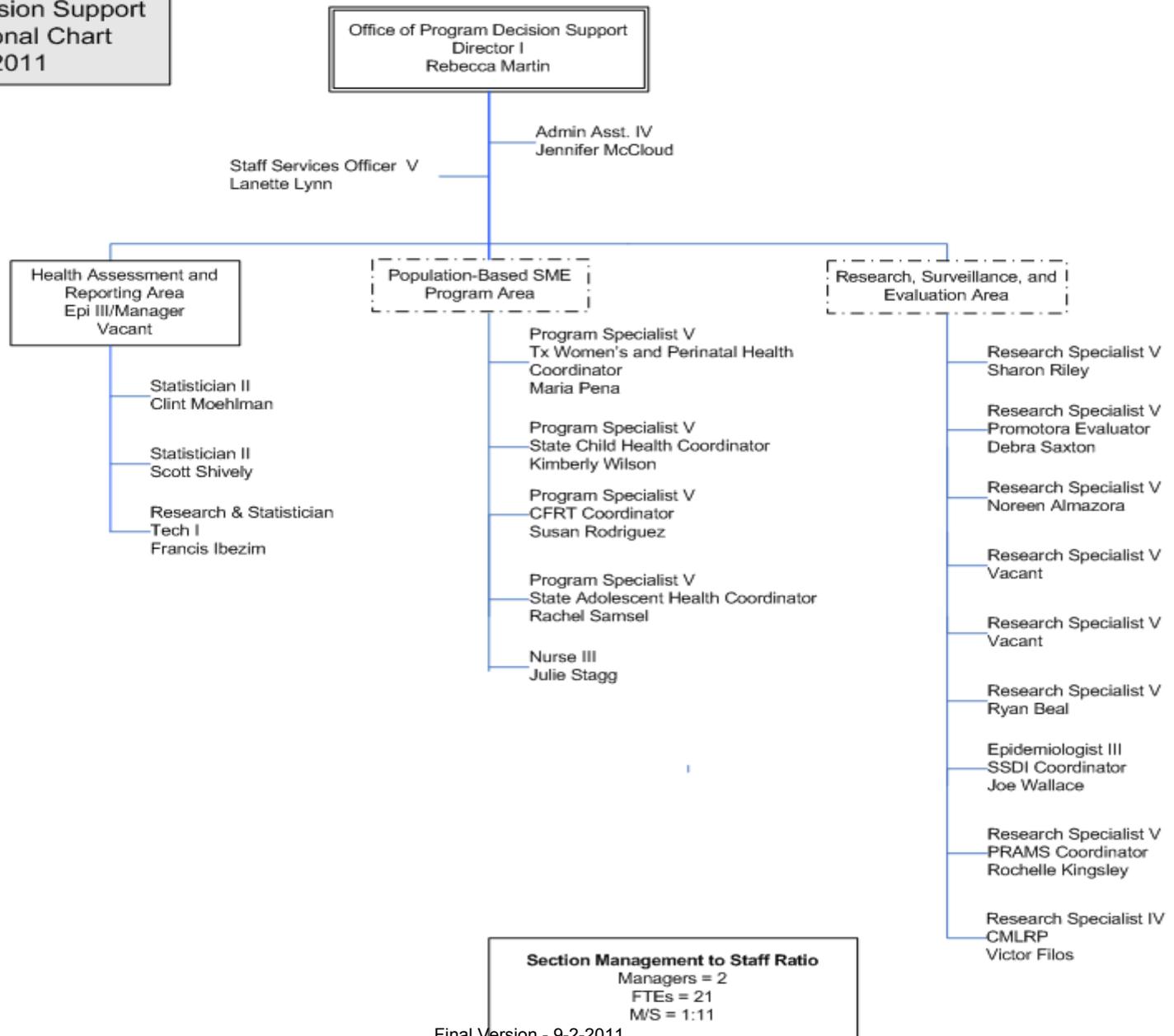
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**Office of Title V & Family Health
Organization Chart
May 2011**

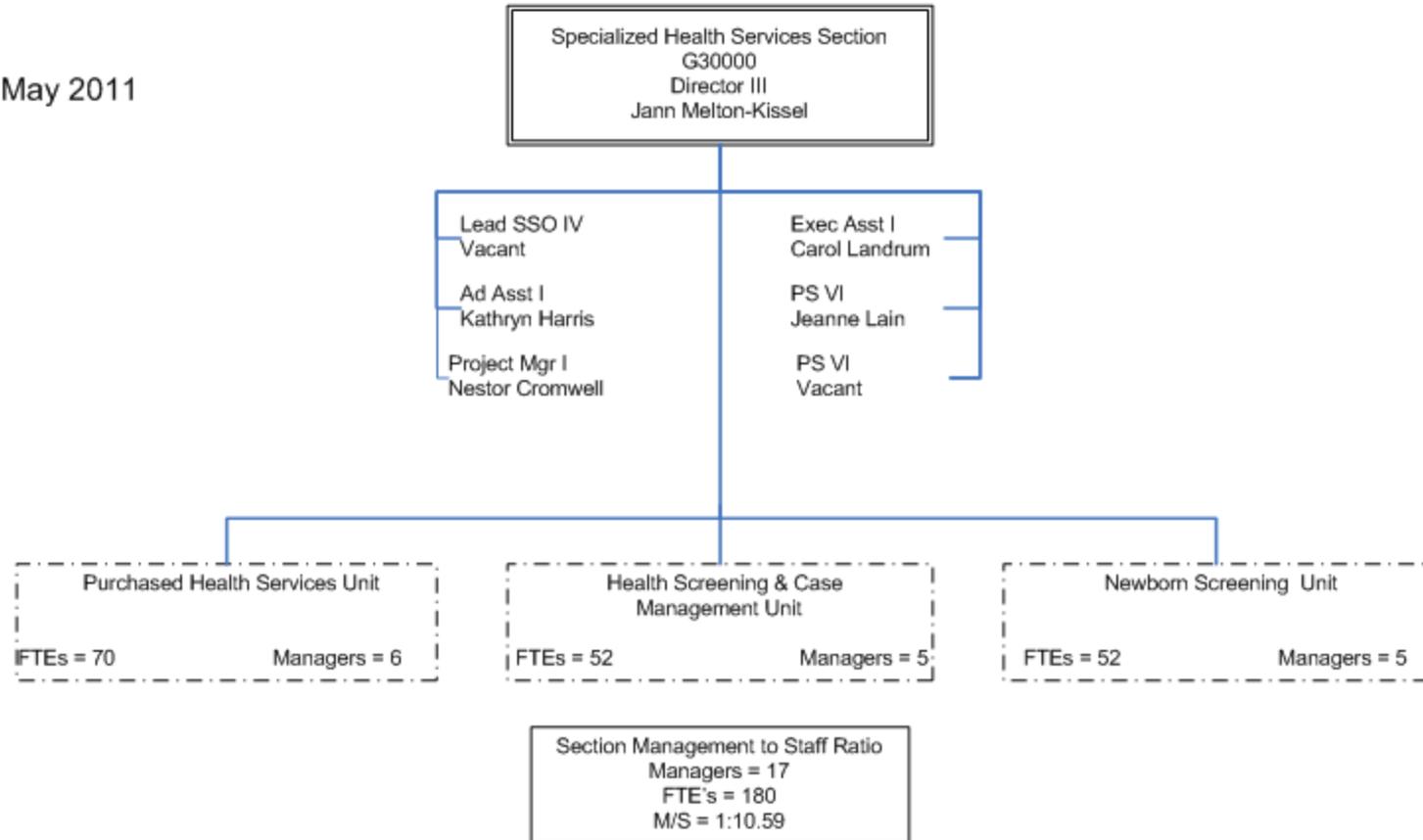


**Program Decision Support
Organizational Chart
May 2011**



Section Management to Staff Ratio
 Managers = 2
 FTEs = 21
 M/S = 1:11

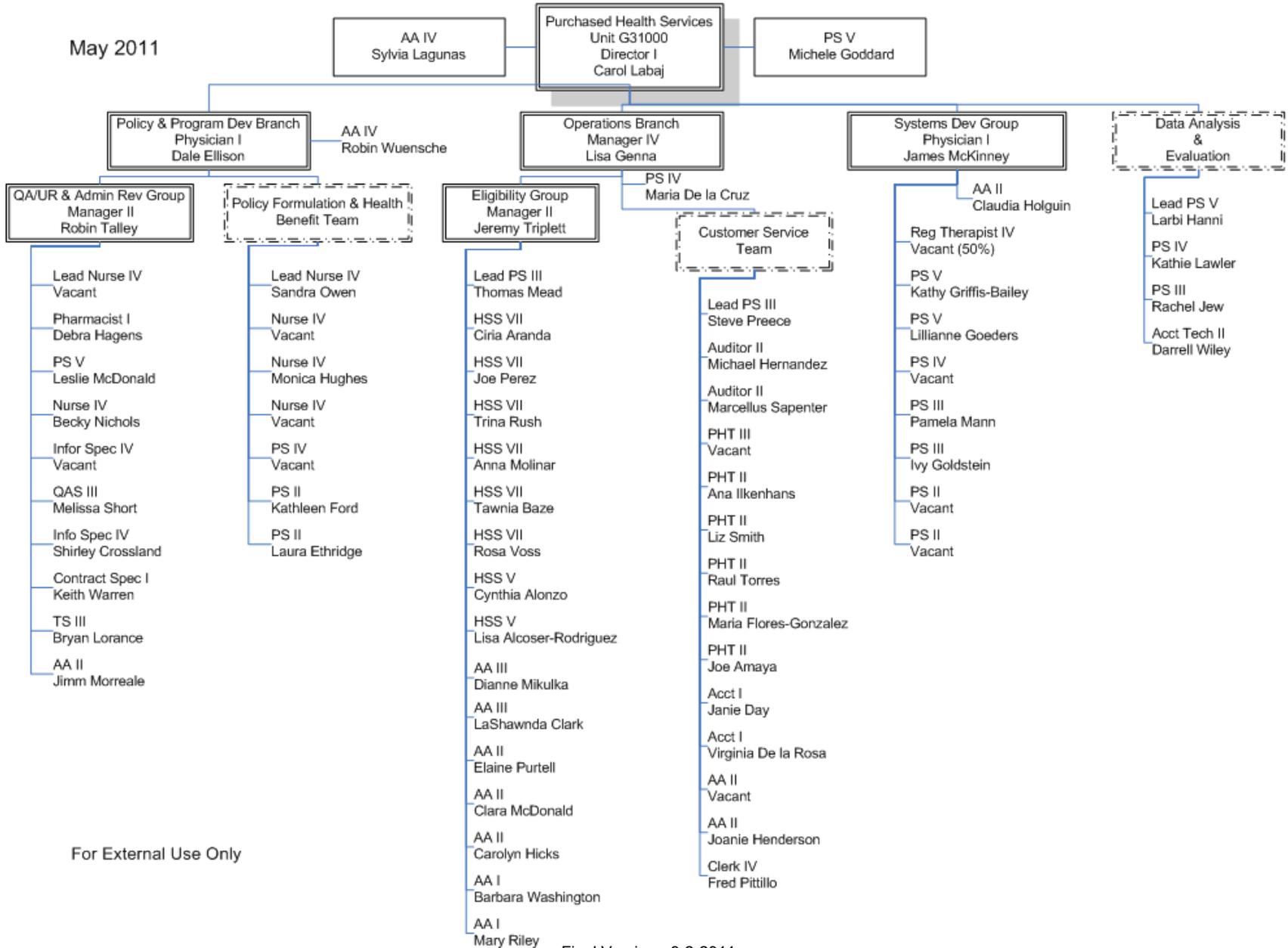
May 2011



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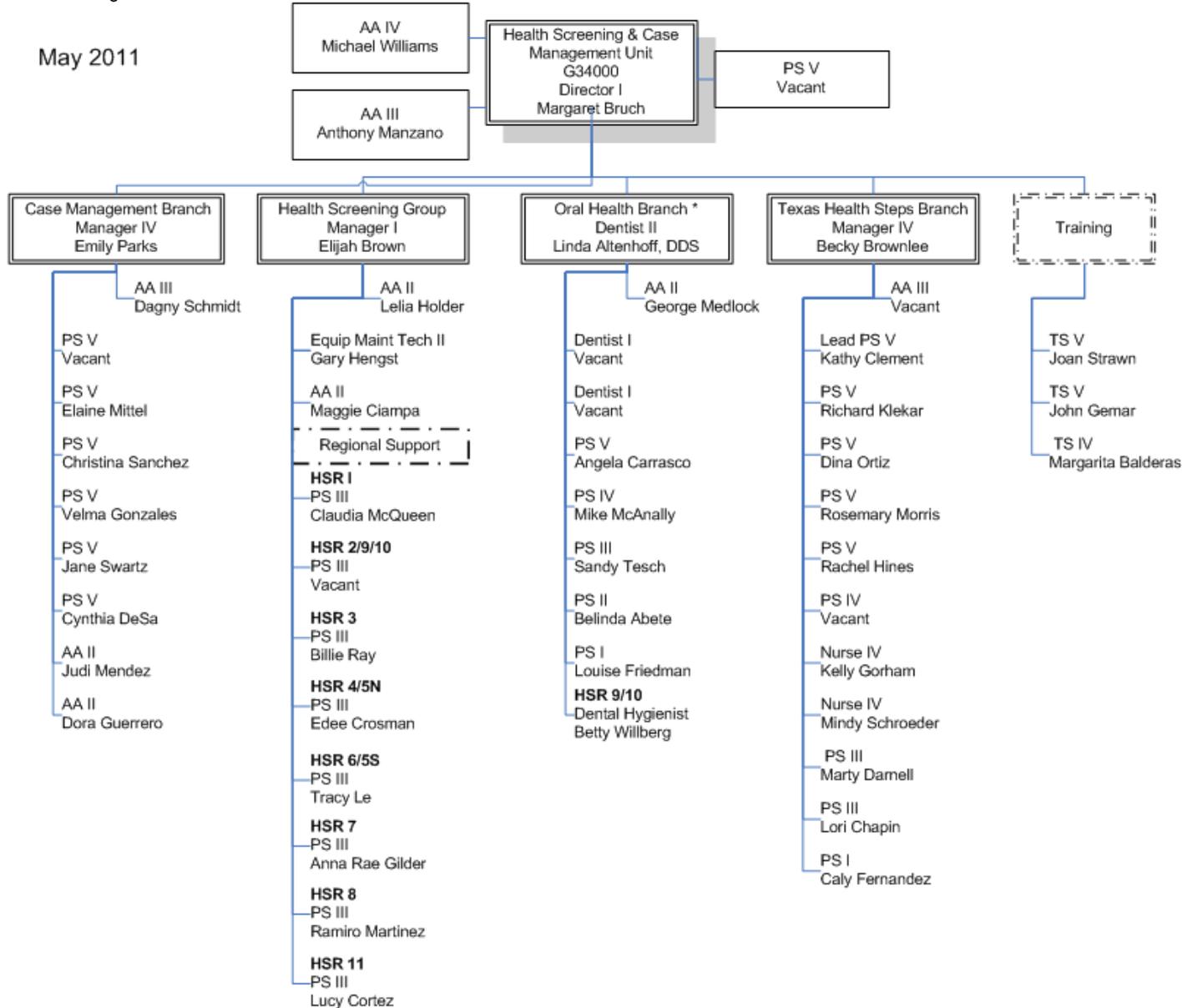
Attachment III. C. Organizational Structure

May 2011



For External Use Only

May 2011



May 2011

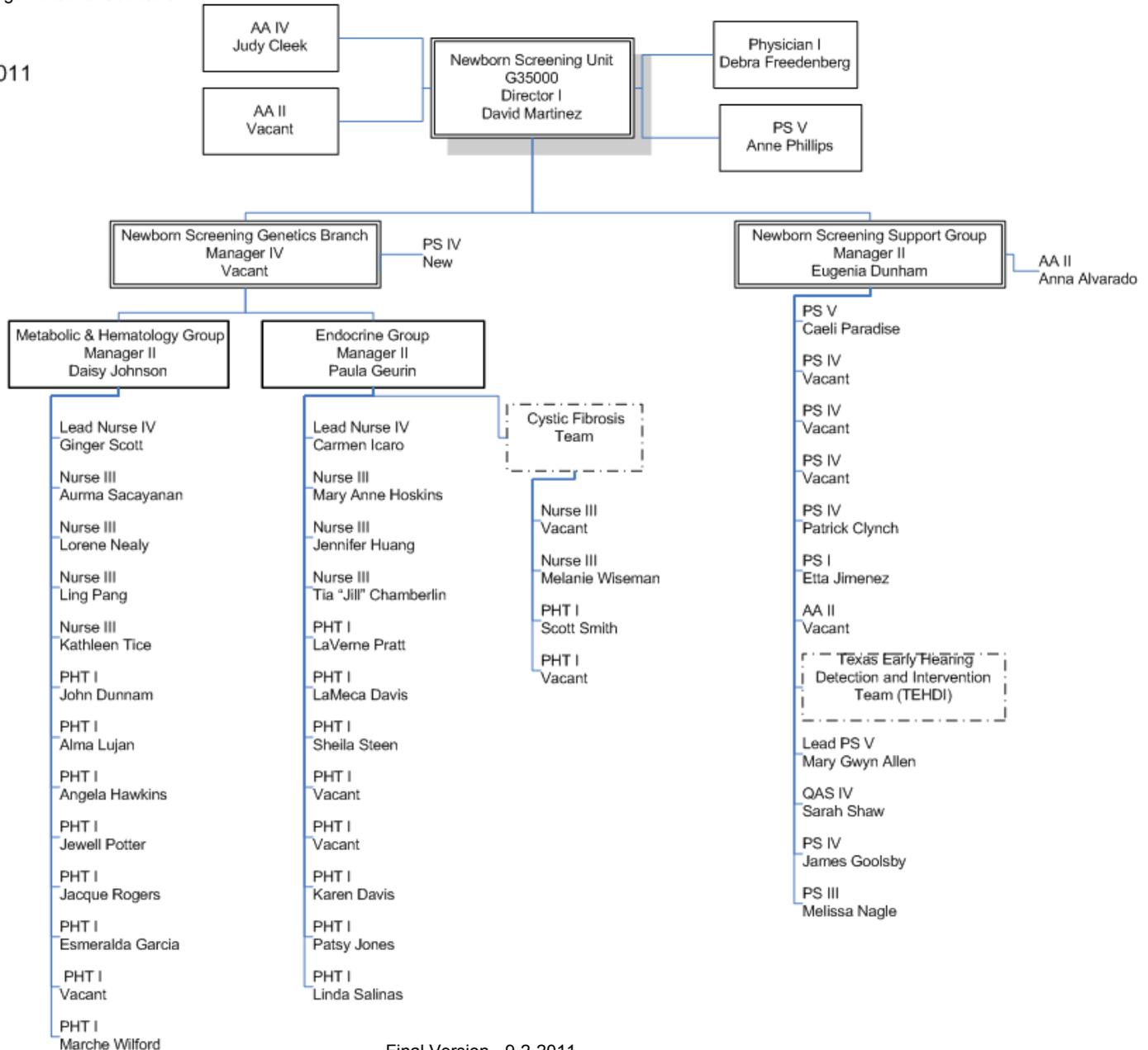


Table 1: FY11 Number and Classifications of DSHS Personnel Funded by the Federal-State Title V Program

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	0.5										0.5
Administrative Asst	16.5	1.6	8.9	0.8	4.1	2.5	2.5	5.5	5.4	31.3	47.8
Attorney	0.2										0.2
Clerk	1.0			0.9			3.6	0.7	2.3	7.5	8.5
Contract Specialist	0.8										0.8
Data Base Administrator	0.6										0.6
Dentist	0.0				0.9					0.9	0.9
Dental Hygenist	0.0				1.0					1.0	1.0
Dietetic & Nutrition Specialist	0.1										0.1
Director	3.5										3.5
Engineer	1.0										1.0
Engineering Specialist	1.0										1.0
Epidemiologist	3.5										3.5
Equipment Maintenance Tech	0.5										0.5
Executive Assistant	2.0										2.0
Financial Analyst	0.8										0.8
Grant Coordinator	0.1										0.1
Human Services Specialist	4.5	3.1	3.7	7.9	9.3	3.1	3.4	2.7	5.3	38.5	43.0
Human Services Technician	0.0			4.1		7.0	5.9	4.6	2.0	23.6	23.6
Information Specialist	4.2										4.2
Laboratory Technician	5.0										5.0
Licensed Vocational Nurse	0.0								1.0	1.0	1.0
Manager	11.1	1.2	0.4	0.3	0.6	1.4	1.4	0.4	1.3	7.0	18.1
Medical Technologist	45.0										45.0
Microbiologist	7.0										7.0
Network Specialist	0.2										0.2
Nurse	10.0	2.0	4.3	9.9	3.2	4.9	8.9	7.7	3.0	43.9	53.9
Nutritionist	0.0			1.0						1.0	1.0
Pharmacist	0.4										0.4
Physician	3.3									0.0	3.3
Physician Assistant	0.0			1.0						1.0	1.0
Program Specialist	49.9	2.1	5.7	2.8	4.6	6.0	2.2	2.7	1.9	28.0	77.9
Program Supervisor	6.0										6.0
Programmer	0.1										0.1
Public Health Nurse	1.0										1.0
Public Health Technician	18.0			2.5	3.0	1.5	0.3	0.4	4.7	12.4	30.4
Quality Assurance Specialist	0.6										0.6
Receptionist	0.0								0.5	0.5	0.5
Registered Therapist	1.0										1.0
Research & Statistics Tech	0.3										0.3
Research Specialist	1.3										1.3
Social Worker	0.0	0.3								0.3	0.3
Staff Services Officer	3.0										3.0
Statistician	0.9										0.9
System Analyst	6.6										6.6
Training Specialist	0.4										0.4
Total	211.86	10.3	23.0	31.2	26.7	26.4	28.2	24.7	27.4	197.93	409.8

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.



2010 report



PROMOTING HEALTHY CHILDREN



STRENGTHENING FAMILIES

BELIEVE



SUPPORT



2010
report



Texas Council on Children and Families

PROMOTING HEALTHY CHILDREN STRENGTHENING FAMILIES

DEVELOP



IMPROVE





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EXECUTIVE SUMMARY

The Texas Council on Children and Families, a newly-formed state level interagency body created in accordance with the Texas Government Code Section 531.801, conducted its first meeting on September 30, 2009. The Council offers this report to the 82nd Legislature with the overall goal of promoting healthy children and strengthening families through:

- 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 and 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 Council is comprised of executive leadership from health and human services agencies, juvenile justice agencies, the central education agency, the workforce commission, and four representatives from the public. The Council is administratively attached to the Texas Health and Human Services Commission, but is independent in direction.

Within this first year of the Council's operation, members have worked toward developing effective strategies to meet the requirements as statutorily charged. Several of those products and activities included:

- an inventory of the state's interagency workgroups that relates to children and youth;
- a survey of priority areas from state agency members;
- the development of a collective legislative appropriations request (LAR) analysis report, including a compilation of data from the fiscal year 2010 operating budget and the fiscal year 2011 appropriations across Council member agencies;
- recommendations to the 82nd Legislature; and
- establishment of objectives for the Council's work to further develop and maintain a statewide system of quality health, education, and human services for children and families.

The Council gathered input from public members, communities and model programs in preparation for developing legislative recommendations and planning toward future work objectives. The following two recommendations to the 82nd Legislature are proposed with the intent of promoting healthy children and strengthening families in Texas.



1. The 82nd Legislature should authorize the development of Regional Leadership Councils on Children and Families.

A regional interagency infrastructure will unite local agency and community leaders from across health, education, juvenile justice, workforce and social services to identify the strengths and challenges of children and families in their community, and to develop an informed local response appropriate to the needs and resources of the community. Through such a regional interagency infrastructure, the Council will be able to establish a clear line of communication from communities to state decision-makers to better inform policy and practices. Additionally, the Council will be able to identify and recognize promising practices and areas of excellence from the smallest to the largest communities in Texas, and promote the replication of local programs as appropriate and within current resources in other communities in the state. These regional councils should be developed within existing resources.

2. The 82nd Legislature should authorize the Council on Children and Families to study and recommend an efficient organization of state level children's councils, workgroups, and committees.

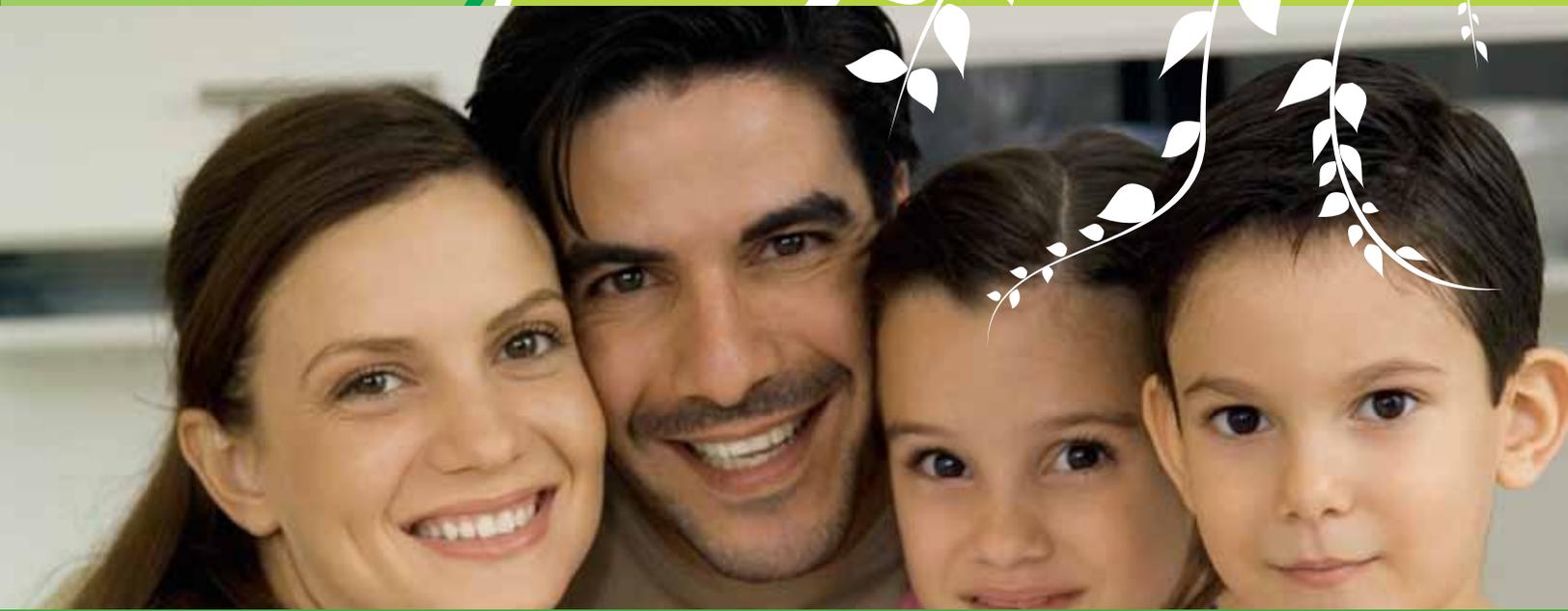
By conducting a critical review of existing state level councils, committees, and workgroups, the Council will be able to propose a more efficient cross-agency system that better utilizes the time and effort of stakeholders and public servants, and result in more effective partnerships that serve Texas children and families. Significant talent and expertise lies within the public and private provider arena, advocacy organizations and people who receive services. Guiding this collective energy in a structure that is streamlined and clear to all will serve Texas well.

Priority Issues

Using information and data gathered, including public testimony and input provided by the Council's family and youth representatives, priority issues have been identified to formulate an initial plan within the following areas:

- early childhood,
- mental health/behavioral health,
- youth transitioning to adults, and
- fiscal opportunities.

The Council has scheduled a work session for January 2011 to further develop its strategic vision, goals and action plan for the priority issue areas outlined in this report, including but not limited to the identification and establishment of timelines, outcomes, benchmarks and responsible parties.



INTRODUCTION

The Texas Council on Children and Families is a newly formed interagency body created in accordance with the Texas Government Code Section 531.801 (see Appendix A). The first Council meeting convened on September 30, 2009. The Council is established to:

- coordinate the state's health, education and human services systems to ensure that children and families have access to needed services;
- improve coordination and efficiency in state agencies, and advisory councils on issues affecting children and local levels of service;
- prioritize and mobilize resources for children; and
- facilitate an integrated approach to providing services for children and youth.

One of the requirements of the Council is to develop a legislative report regarding "child welfare" not later than December 1 of each even-numbered year. This report is to contain:

- the requests, plans and recommendations of the Council, including recommendations of any legislation that is needed to further develop and maintain a statewide system of quality health, education and human services for children and families; and
- information regarding the implementation by the members of the Council of any method, process, policy, or recommendation, including information regarding whether the implementation has proceeded in accordance with the timeline, outcome and benchmarks identified by the Council.

This document serves as the 2010 report.

Council Membership

The membership on the Council (see Appendix B) is comprised of executive leadership from health and human services agencies, juvenile justice agencies, the central education agency, the workforce commission and representatives from the public as follows:

- the Executive Commissioner of the Texas Health and Human Services Commission (HHSC);
- the Commissioner of the Department of State Health Services (DSHS);
- the Commissioner of the Department of Family and Protective Services (DFPS);
- the Commissioner of the Department of Aging and Disability Services (DADS);
- the Commissioner of the Department of Assistive and Rehabilitative Services (DARS);
- the Commissioner of the Texas Education Agency (TEA);
- the Executive Director of the Texas Juvenile Probation Commission (TJPC);
- the Executive Commissioner of the Texas Youth Commission (TYC);
- the Executive Director of the Texas Workforce Commission (TWC);
- the Director of the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI);
- two public representatives who are parents of children who have received services from an agency represented on the Council, appointed by the Texas HHSC Executive Commissioner; and
- two representatives who are young adults or adolescents who have received services from an agency represented on the Council, appointed by the Texas HHSC Executive Commissioner.

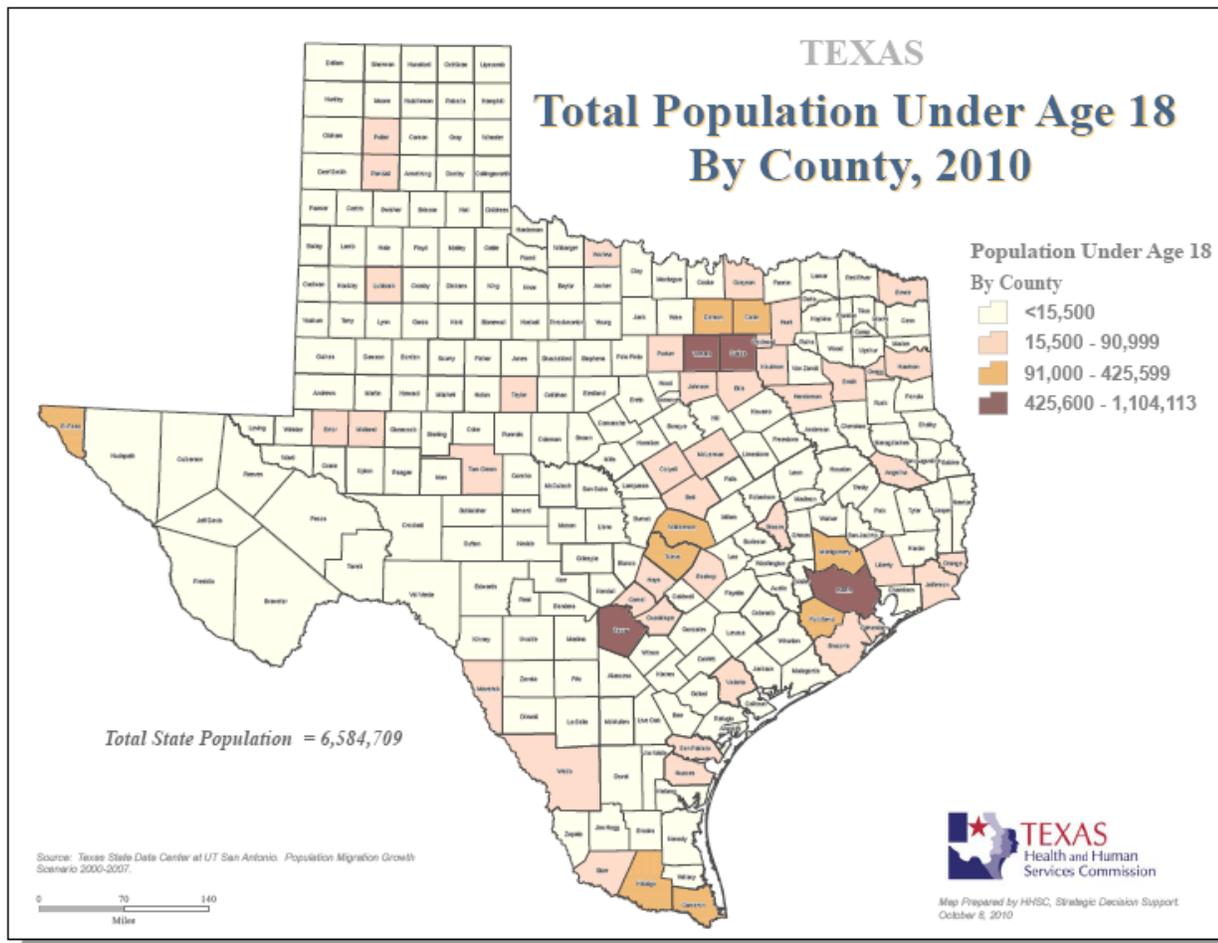
The Council is administratively attached to HHSC, but is independent in direction. Council members have determined an infrastructure through approval of operational guidelines and election of leadership.

A Snapshot of Texas

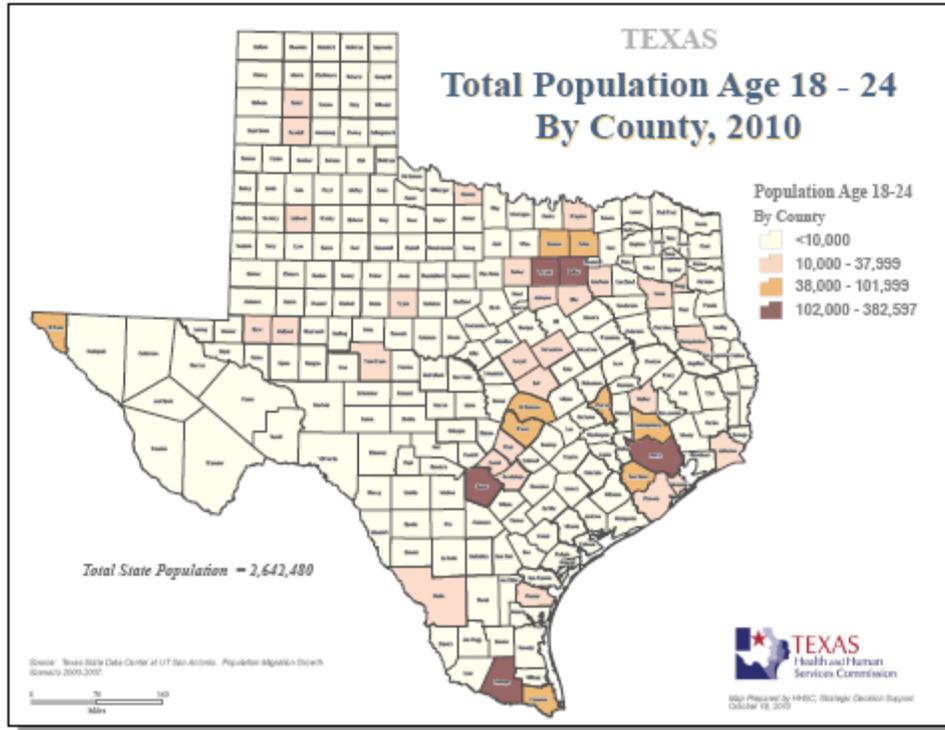
The Council on Children and Families is to consider the welfare of all children in Texas, with the dual aim of promoting healthy children and strengthening families. According to the statute, the Council shall:

- promote a common vision of desired outcomes for children and youth, and of family and community supports;
- promote shared accountability for outcomes for children and youth; and
- align allocation of resources with policies for children and youth.

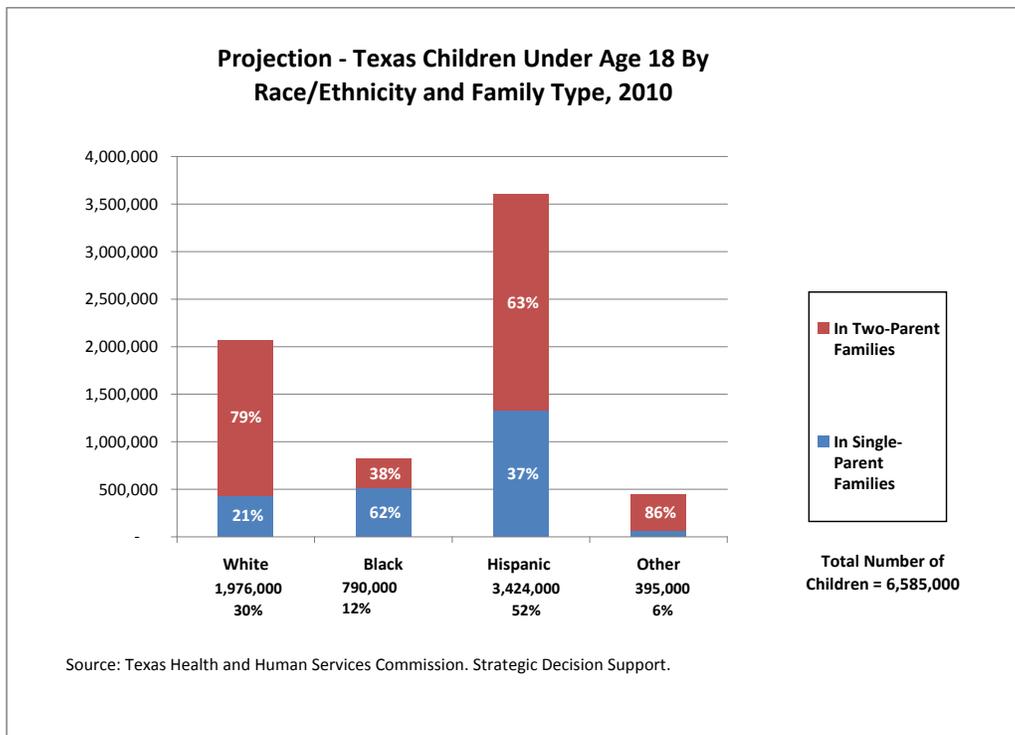
The current population of children (under age 18) in Texas is 6,584,709. The map below shows the distribution of the child population in Texas.



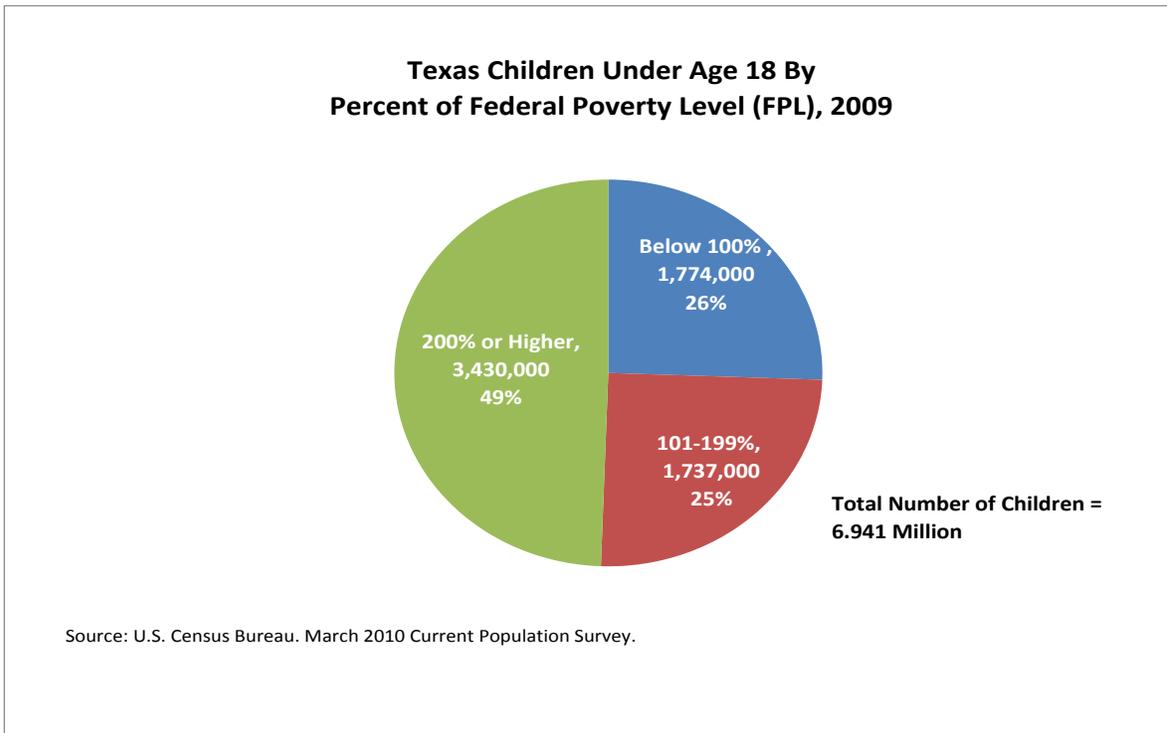
In addition to the overall child population, the Council is concerned with youth transitioning to healthy and successful adulthood. The population of youth (age 18 through age 24) in Texas is 2,642,480. The map below depicts the distribution of the youth population in Texas.



According to the Texas Health and Human Services Commission for calendar year 2009, Hispanic children constitute 53 percent of the population under age 18.



When vulnerable populations are considered, such as children living in poverty, 51 percent of Texas children are in homes below the 200 percent federal poverty level for 2009.



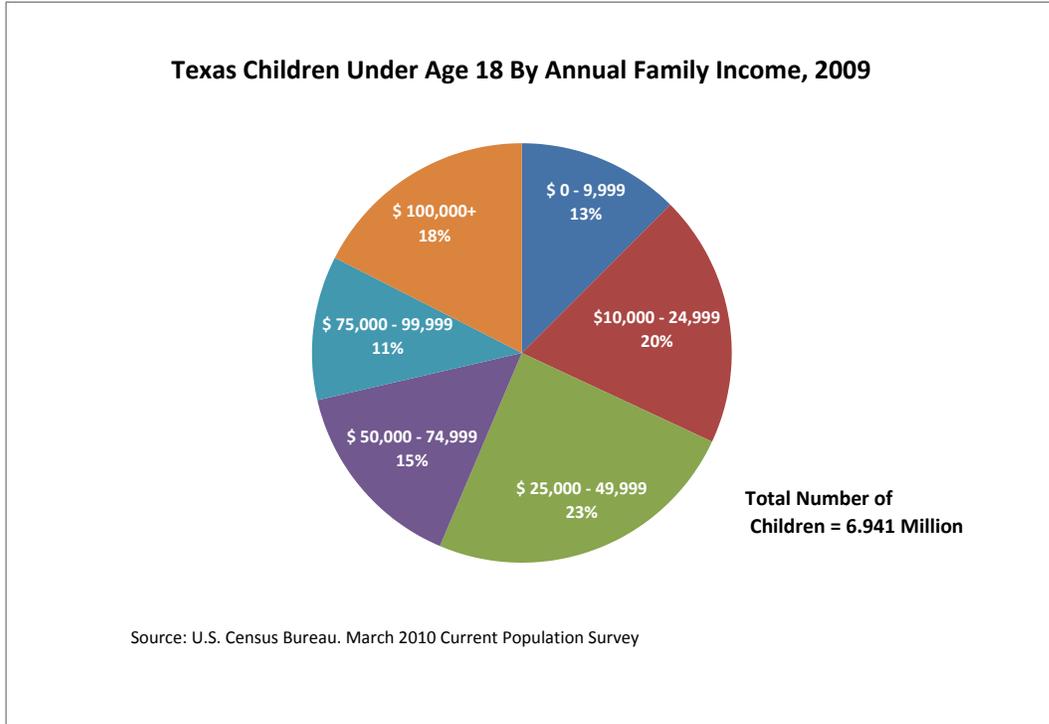
The chart below shows the 2010 Federal Poverty Level Guidelines based on the annual household income. The graph on the next page outlines annual family income for children under age 18 for calendar year 2009. Note that 33 percent of children are living in homes with an income below \$25,000 a year.

**The 2010 Poverty Guidelines for the 48
Contiguous States and the District of Columbia**

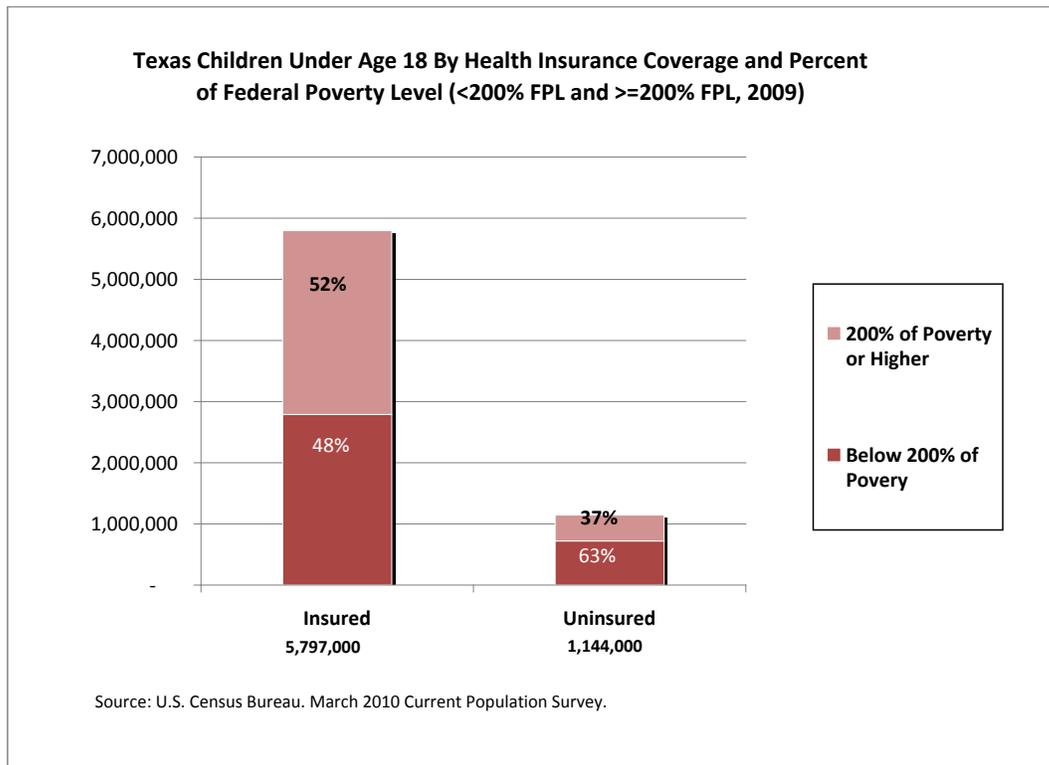
Persons in family	Poverty Guideline (Based on Annual Income)
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add \$3,740 for each additional person.
Assistance Secretary for Planning and Evaluation (ASPE).

SOURCE: Federal Register, Vol. 75, No. 148, August 3, 2010, pp. 45628–45629.
Submitted by the U.S. Department of Health and Human Services;



Children not covered by insurance often receive services through hospital emergency rooms, local health clinics or federally qualified health clinics. The graph below reflects both the number of children insured and those uninsured in accordance with the number of children within the federal poverty level.



This data provides a compelling backdrop for the necessity of promoting healthy children and strengthening families in Texas through a collaborative effort.

Children's Interagency Workgroups Inventory

Within the first year of the Council's operation, members have worked toward developing effective strategies to meet the statutory requirements. The Council has taken steps to gain a better understanding of the "landscape" of existing state level workgroups and committees that address children and youth services. An inventory of the state's interagency workgroups was conducted and aligned into eight categories:

- early childhood detection and intervention,
- education,
- health care,
- long-term community-based services and supports,
- mental health,
- juvenile justice,
- transition issues, and
- crisis prevention and intervention.

Agency Major Issue Areas

To help prioritize its initial efforts, Council members were asked to provide input on areas or populations of interest. The most frequent issue areas identified in ascending order were:

- mental health and/or behavioral health;
- early childhood and/or early intervention; and
- transition issues.

These areas provide a starting point to examine several priority areas.



LEGISLATIVE APPROPRIATIONS REQUESTS ANALYSIS

One of the Council's legislative requirements is to analyze the biennial legislative appropriations requests (LARs) of Council member agencies for services provided to children and their families, and prepare a report no later than May 1 in even-numbered years (see Appendix C).

The May 2010 LAR report identified appropriations that, through modifications in member agencies' next biennial LARs, could eliminate waste or increase available services. The authorizing statute calls for the Council, through the LAR analysis, to:

- investigate opportunities to increase flexible funding for health, education and human services provided to children and their families;
- identify methods to remove barriers to local coordination of health, education and human services provided to children and their families;
- identify methods to ensure that children and youth receive appropriate assessment, diagnoses and intervention services;
- develop methods to prevent unnecessary parental relinquishment of custody of children;
- prioritize assisting children in family settings rather than institutional settings; and
- make recommendations about family involvement in the provision and planning of health, education and human services for a child, including family partner and liaison models.

Criteria for Data Used in LAR Analysis Report

The eight categories, as determined in the inventory of children's interagency workgroups (noted on page nine of this report), became the underlying foundation for the listing of budget strategies in the template developed for the May 2010 LAR analysis report. An additional ninth category of "other" was included to allow for budget items targeting children and families that did not align within the eight identified categories.

The LAR Analysis

The LAR analysis used data collated from fiscal years 2010 and 2011 (Appendix C). The report contained the following recommendations:

- The data collected from fiscal years 2010 and 2011, in the proposed format of nine categories, will serve as the baseline in future biennial LAR analysis reports, for comparisons and as the basis for further analysis.
- The fiscal data from the top three issue areas (mental/behavioral health services, early childhood/early childhood interventions and transition issues) will serve as the initial target areas for deeper analysis and development of recommendations.
- The Council will develop and adopt a template to be used for further analysis of the LAR data in the initial targeted categories.





RECOMMENDATIONS TO THE 82nd LEGISLATURE

The following recommendations to the 82nd Legislature, along with the priority issues and related initial implementation plans have been established with the intent of promoting healthy children and strengthening families in Texas. The recommendations and plans fall within statutory guidance, which calls for the Council report to include:

- the requests, plans and recommendations of the Council, including recommendations of any legislation that is needed to further develop and maintain a statewide system of quality health, education and human services for children and families; and
- information regarding the implementation by the member agencies of the Council of any method, process, policy or recommendation, including information regarding whether the implementation has proceeded in accordance with the timeline, outcome and benchmarks identified by the Council.

Recommendations for Cross Agency/System Issues

Ideally, children live in families, and families live in communities. Within its borders, Texas covers a vast geographical area of 254 counties rich in a diversity of cultures, resources and concerns for its children and youth, and their families.

An increasing number of children, youth and families need access to health care and social support services; many students need these types of services to succeed in school. The number of children who use drugs, drop out of school, join gangs and engage in other risky behaviors is rising. Families frequently report that if services are available, many times they are inaccessible, fragmented, redundant or restricted by eligibility or burdensome requirements.

Although Texans share common concerns for their children, some communities face unique problems. For example, children's health issues may be manifested differently in south Texas than in the Panhandle, thus magnifying the need for communities to have the flexibility and authority to respond and maximize resources to their own distinctive situations. A statewide infrastructure that establishes a clear line of communication from communities to state decision-makers would better inform policy and therefore, practice. This collective, interagency community voice, that speaks for the needs of its children and families, and that can convey its promising practices, would benefit state-level policymakers.

Why Is This Important?

The Council is comprised of ten state agencies and four public representatives. As it has organized to meet the statutory charge and to collaboratively respond to the needs of children, youth and their families, there has been a desire to hear from communities about their needs as well as their "wins."

Each Council member shares challenges and successes according to their particular focus population, ranging from the vantage point of juvenile justice, workforce, education, child protection or a specific disability. The Council's charge is to cast a broad net to look at promoting the wellness of children, youth and families as well as to provide a safety net to more vulnerable populations, including children and

youth with disabilities. It would be advantageous to create a statewide infrastructure that promotes communities assessing their priorities and assets for children and families from a regional vantage point, and then communicating that information to the Council. Establishing a clear line of communication between communities to regions and the state will assist in breaking up the siloed and fragmented approaches to serving Texas' children, youth and families.

How Is Texas Doing?

There are plenty of examples of small, local, and limited scope cross-agency initiatives throughout the state. One recent example comes from H.B. 1232, 81st Legislature, Regular Session, 2009, which established a pilot project in Bexar County to improve collaboration between DSHS, DFPS, TYC and TEA relating to behavioral health intervention. While the legislation dealt with a number of specific issues relating to behavioral health, information sharing and consent, it also contained a number of provisions that could be considered as a basis for building upon in establishing a collaborative cross system structure to improve services for children, including provisions regarding: collaboration in the provision of services to children; the development of a best practices plan in collaboration with the state and local agencies; uniform referral processes between systems and agencies; an information exchange process, and; the identification of outcome measures that may be used to measure the efficiency of coordination.

While the Council recognizes there is great work occurring within Texas communities, it also recognizes a need to shore up services and supports in many areas of the state as well. Currently, the approaches to obtain and prioritize this information are fragmented, and are usually based on a particular pressing issue.

There is not a common regional designation that crosses the state among state agencies serving children, youth and families. There are at least four different regional designations across the state represented by Council agencies: 11 health and human services regions, 20 educational regions, 7 juvenile probation regions, 4 juvenile correction districts and 28 workforce areas. (See Appendix E for regional maps.)

There is not a systematic construct within the state that provides a consistent method for a state or local entity to pass needed information up or down the chain of decision makers for consideration for action. This is especially true for the promotion of collaboration in interagency service delivery.

Families often navigate between multiple systems. Communities that have ongoing access to the data, people and policies that drive the many components of the local system, are in a better position to create a more effective and manageable system for families. A community that is coordinated and informed about the systems operating across the community is better poised to prioritize and mobilize available resources, especially during times when those resources are limited, and is therefore, in a better position to control its outcomes.

Texas Councils of Governments



Final Version - 9-2-2011

Recommendation I: The 82nd Legislature should authorize the development of Regional Leadership Councils on Children and Families.

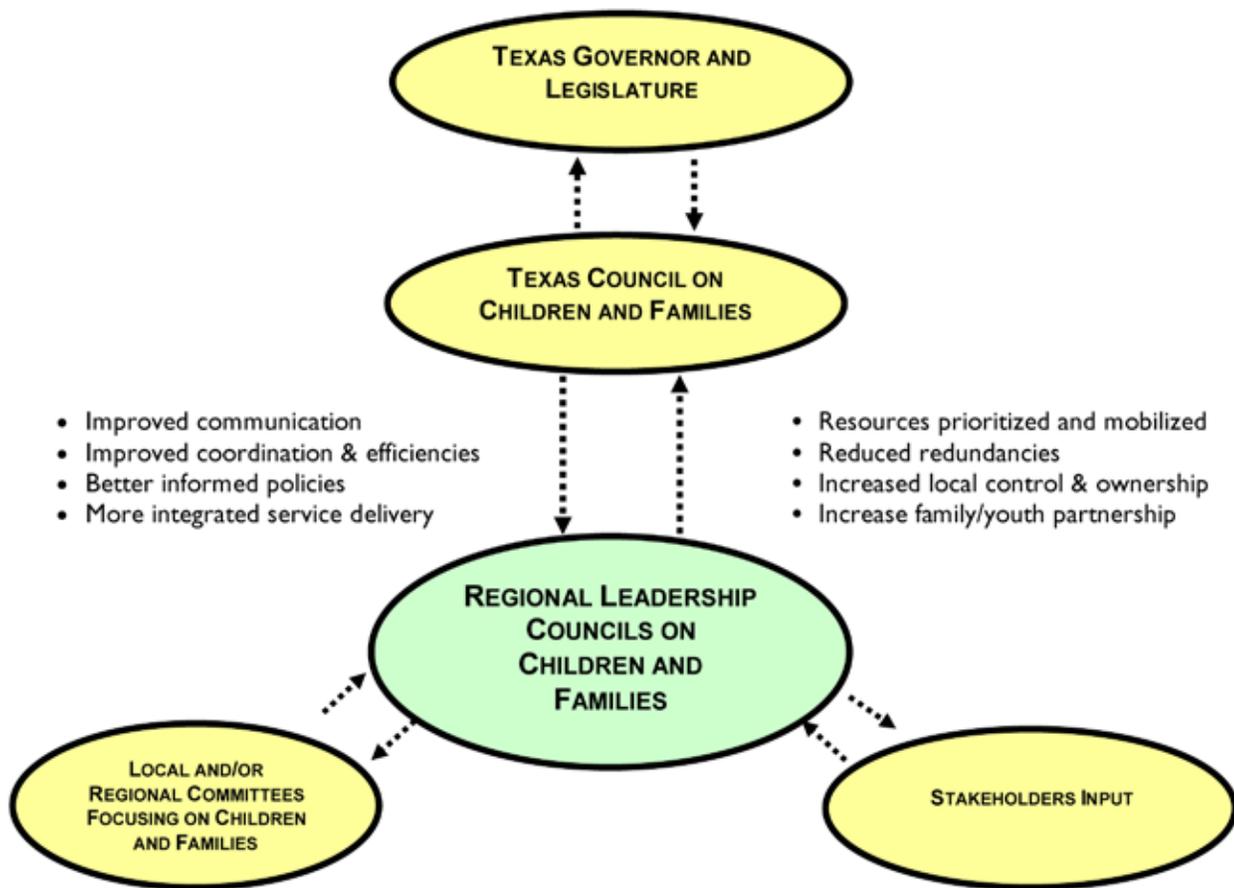
The purpose for a system of Regional Leadership Councils on Children and Families is to reduce redundancies and improve coordination, collaboration and efficiencies among local health, education, juvenile justice, workforce and social service systems to better serve children and families. (See Appendix F for additional information.)

The following are suggestions for consideration in authorizing and developing these councils.

- Local/regional areas are best positioned to identify the appropriate entity to lead the regional councils. Each region may create a new council, or may build on an existing local/regional council, committee or other infrastructure. Regional Council's of Government should lead a local process to identify a lead entity to oversee and support the regional leadership council.
- Roles and responsibilities of the regional leadership councils should be identified to be accomplished within current resources. Statute should provide broad guidance, but allow for maximum local control in defining roles and responsibilities, which may include but not be limited to:
 - conducting regional asset inventories and needs assessments;
 - developing regional plans, with an emphasis on reducing redundancies, and improving coordination and efficiencies;
 - prioritizing and mobilizing available resources;
 - identifying and communicating to the Council evidence-based collaborative local programs and practices that could be shared across the state for other local communities to consider for replication;
 - providing recommendations to the Council for improvements in state policies to increase efficiencies and positive outcomes at the local level; and,
 - providing for a coordinated response, and leveraging local funding when seeking additional federal, foundation or other private funds for use at the local and/or regional level.
- To the extent possible, local leadership councils should utilize the work and activities of other local committees focused on child and family services, and may look for opportunities to consolidate local committees as appropriate and feasible. While single issue area, or single project focused committees may continue to exist, local leadership councils should work to ensure coordination and communication between these committees.
- The regional leadership councils should be geographically aligned with an existing regional structure such as the regional Councils of Government. (See Appendix E for a comparison of existing regional service divisions in Texas.)
- Guidance should be given on the composition of the regional leadership councils to determine common membership, as well as to allow for unique community members who are stakeholders for children, youth and families (i.e., local elected officials, family and youth representation, regional community-based, child-focused organizations).

- The responsibilities of state agencies and state councils, in assisting the work of the regional leadership councils should be identified (i.e., Council member agencies may provide available support in the form of needed data, reliable methodologies for community assessment and asset inventory, and/or strategies for local agency staff support for regional councils).

Regional Leadership Councils on Children and Families



Recommendation 2: The 82nd Legislature should authorize the Council on Children and Families to study and recommend an efficient organization of state-level children’s councils, workgroups, and committees.

The Council on Children and Families should study and make recommendations to the 83rd Legislature regarding opportunities to promote efficiencies and reduce redundancies across and among advisory committees and workgroups that address services to children and youth. In accordance with existing protocols, including Chapter 2110, this should be a systemic review that will take into consideration advisory committees across health and human services, education, juvenile justice and workforce, and should review opportunities to revise and/or update committee charges, and combine, consolidate or eliminate committees as appropriate. The Council has taken a step in that direction with its initial work in the development of an inventory of state-level workgroups (see Appendix D).



PRIORITY ISSUES

The Council has drawn from input provided by the Council's family and youth representatives, public testimony at Council meetings, and information and data gathered from agencies and other sources to formulate initial implementation plans in the following areas:

- 1) early childhood,
- 2) mental health/behavioral health,
- 3) youth transitioning to adults, and
- 4) fiscal opportunities.

Within these priority areas, the Council has identified methods, processes and policies to be included in the development of an implementation plan. Further development of this plan will include the establishment of timelines, outcomes and benchmarks and the identification of responsible parties.

The Council is actively learning about successful family partner/liaison programs and youth behavioral intervention pilots, including the following two models presented during Council meetings in 2010:

- The Travis County Children's Partnership Collaborative meets the complex needs of children and youth with serious emotional disturbances in Travis County by maintaining a collaborative system of care comprised of community partners. A service plan, unique to each child and youth, assists families in navigating the system of care; this plan is based upon family needs and preferences and has an ultimate goal of preventing out-of-home placement.
- The multi-agency initiative, "Bexar Cares," (based in Bexar County) has been charged by H.B. 1232, 81st Legislature, Regular Session, 2009, with demonstrating whether the provision of intense, community-based, coordinated behavioral health services is successful at preventing youth with mental illness from exiting school or entering juvenile justice facilities.

The Council continues its process of identifying assets within the state, and has discussed the importance of, and commitment to, obtaining feedback from community service providers. It has recently held a public hearing to gather feedback on its initial work. All this information will be used to further develop the implementation plan.

The Council has scheduled a work session for January 2011 to further develop its strategic vision, goals and action plan for the priority issue areas outline in this report, including but not limited to the identification and establishment of timelines, outcomes, benchmarks and responsible parties.

I. Early Childhood/Early Intervention

A significant number of young children do not receive recommended health and developmental screenings, and those screening tools found to be most accurate in detecting developmental issues are frequently not used. Thus, problems are often not detected until a child enters school, by which time problems may have worsened and be more costly to address.

The effects of the problems on school readiness and social functioning may be more difficult to mediate. Extensive research demonstrates that early childhood is a critical time for brain development and that the child's early experiences affect subsequent school and life success. Specific factors (including poverty, child maltreatment, parental mental health, substance abuse and family violence) increase the risk of a child developing health, behavioral, developmental and learning problems. Moreover, the research shows that addressing health, social-emotional and cognitive development in the early years reaps benefits for the child and the community.

Why Is This Important?

Effective early childhood practices return more to society than they cost. Studies have shown that for children with developmental disabilities or delays, early interventions can have significant academic, social and economic benefits, including an estimated savings to society of \$30,000 to \$100,000 per child through the decrease in spending on special and remedial education, mental health services and other interventions. A recent study of several early interventions programs conducted by the Rand Corporation found an average cost savings per child ranging from \$1.80 to \$17.70 for each dollar spent on early intervention.

Below is a list of reasons why early health and developmental screenings are important.

- Early identification of medical, developmental, behavioral health and learning issues through routine screening is critical to the long-term well-being of children. Developmental and behavioral problems that go untreated in children can have lasting negative impacts.
- The first years of a child's development lay the foundation for cognitive functioning, and behavioral, social and physical health. The crucial influence of the early childhood years on later school success is well-documented (Edwards, et al., 2005).
- Many children face various risk factors (e.g., developmental delays, poverty) that can impede healthy development. Early detection and intervention can result in greater educational success for children as well as identified cost savings (Pinto-Martin, 2005; Rand, 2010).

- In the United States, an estimated 17 percent of children have developmental or behavioral disabilities, yet fewer than 50 percent of these children are identified as having a problem prior to starting school (Centers for Disease Control and Prevention, 2010).
- For those who do receive a screening, it is estimated that one in five children with a disability is not identified through a single developmental screening alone (Zero to Three, 2010).
- Research demonstrates that informal assessment alone detects fewer than 30 percent of children with developmental disabilities, whereas standardized screening tools can identify children with developmental issues or delays 70 percent or more of the time. A survey conducted by the American Academy of Pediatrics (AAP) found that 71 percent of pediatricians use informal clinical assessments to assess developmental milestones. Only 23 percent of doctors report consistently using a standardized screening tool to conduct developmental screenings (Sand et al., 2005).
- Below are links and references to several reports on developmental screenings that outline the importance, best practices and alternative settings for conducting the screenings.
<http://eccs.hrsa.gov/Resources/docs/dsecsreport508C.pdf>
<http://www.cdc.gov/ncbddd/child/improve.htm>
<http://www.aap.org/healthtopics/early.cfm>

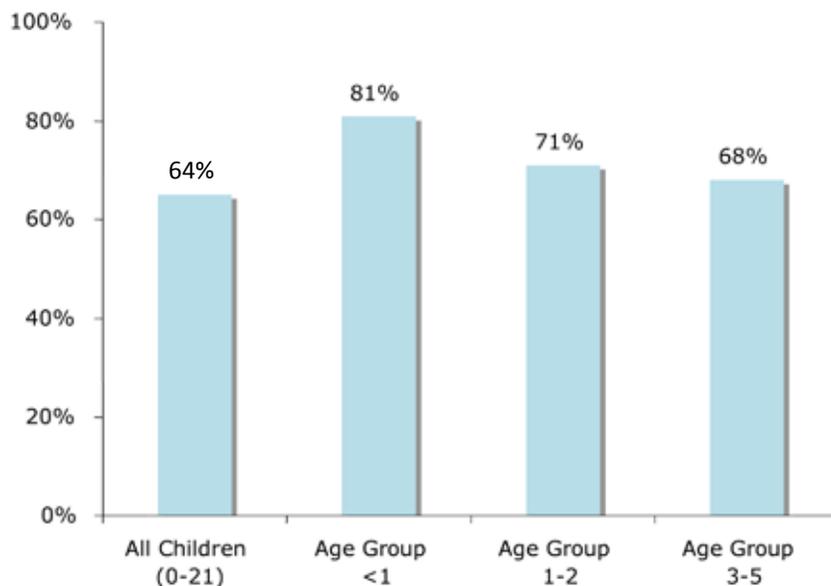
How Is Texas Doing?

Texas has developed some strategies to address early screening and detection. A few examples of what Texas is doing are as follows.

- Texas Health Steps (THSteps), the state's Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, provides screening services for children who are eligible for Medicaid.
- The state periodicity of screening schedule mandates medical and behavioral health screenings throughout the first 20 years of life, and that developmental screens be conducted using a standardized screening tool at 9, 18 and 24 months, and 3 and 4 years of age.
- Standardized tools for which providers can receive separate (additional) reimbursement in Texas include Ages and Stages Questionnaire (ASQ); Ages and Stages Questionnaire: Social and Emotional (ASQ-SE); Parents Evaluation of Developmental Status (PEDS); and Modified Checklist for Autism in Toddlers (MCHAT). Since September 1, 2009, reimbursements are given for the use of standardized assessment tools.

- Over 60 percent of all eligible children had *at least one* THSteps screen. In 2009, 81 percent of eligible children under age 1; 71 percent of children age 1 to 2, and 68 percent of children ages 3 to 5 had received at least one screening in the previous year.

Percentage of Eligible Children Receiving EPSDT Screening Services, 2009



- THSteps is working to increase the number of eligible children who receive required screenings. For instance, THSteps is now communicating directly with families of eligible children to remind them of the upcoming date for their child’s screening.
- Early Childhood Intervention (ECI) conducts developmental evaluations of children ages birth to three regardless of income or insurance. In fiscal year 2009, 55,428 children were screened/evaluated by ECI.
- Texas children who are eligible for CHIP may also receive developmental screenings as part of regular checkups.
- Twenty percent (1.4 million) of Texas children have no health insurance. Just under half of Texas children receive coverage through their parent’s employer (Texas Kids Count, 2010). There are no data sources for determining how many of these children receive regular checkups, and if these routine checkups include developmental screens.
- Early identification of medical and developmental issues would provide information on the prevalence of specific issues that hinder children from being ready for school. However, data is not systematically collected on whether or not a child received required medical and developmental screenings, or whether a child received follow-up referrals and services if identified as having one or more developmental issues.

Implementation Priorities

A developmental screening is a brief assessment used to identify children with potential developmental delays who should receive more intensive assessment or diagnosis. Screenings can be tailored for a specific disorder or designed to encompass multiple areas of concern. Screenings are most often conducted in a medical setting by a medical doctor or paraprofessional, but can also be administered in community or school settings, or by parents. *(Note that these recommendations focus on children ages birth to eight. Early detection of health, behavioral, developmental or other issues is only one step/factor to ensuring children get a great start and are ready to learn.)*

All Texas children ages birth to six should receive recommended screenings in order to identify and address any medical, behavioral, developmental or learning issues as early as possible. The following steps toward this goal are recommended:

- 1) Increase knowledge of the importance of screening and skills needed in conducting screenings through incorporating relevant training into existing training modules [e.g., THSteps, DSHS Child Care, DFPS Child Care Licensing Infant and Toddler, Healthy Child Care Texas – Child Care Health Consultant, Texas - 211 Operators) and resources (e.g., A Parent’s Guide to Raising Healthy, Happy Children (H.B. 1240)]. The training would also increase skills of staff in speaking with parents about the importance of screening, including screening for social and emotional concerns in children, and in making appropriate referrals.
- 2) Develop a website with screening information and resources for parents, guardians and child care providers. Information provided to parents and guardians will include basic, standardized screening tools for parents to use to track their child’s progress, and resources if they need help or services. The website will also have a section for child care providers to help them talk to parents about screenings and potential medical, developmental, behavioral health or learning issues. This could be incorporated into the proposed “A Parent’s Guide to Raising Healthy, Happy Children” website currently being developed at HHSC.
- 3) Provide information on effective screening tools and resources that include social-emotional development, in partnership with medical groups such as the Texas Pediatric Society, to assist Pediatricians in early identification of problems in children. Incorporate information targeted to doctors into the website on screening and resources (See #2 above)
- 4) Increase public awareness about the importance and purpose of regular screening. Special efforts will be made to reach out to provide culturally and linguistically responsive information to specific populations of families including those who are homeless, living in colonias, in or just returning from military service, and other populations that might be identified as needing specialized communications. Agencies will also partner with relevant organizations and groups to reach out to parents, child care providers and the medical community to increase awareness of the importance of screening (e.g., DFPS Child Care Licensing’s infant and toddler trainings, THSteps training, Expanding Opportunities early childhood inclusion team, State Advisory Council on Early Childhood Education and Care). The outreach campaign will also direct people to the proposed website (see recommendation #2 above).

II. Mental Health/Behavioral Health

“Behavioral health” is a term used to refer to both mental health and substance use. Addressing behavioral and/or mental health wellness is a service need for children, youth and families that cuts across many systems. The ongoing need to address healthy social-emotional development of infants throughout young adulthood should be woven into parenting, child care, education, and other points of opportunity. Prevention and early identification of a behavioral health need(s) are chances for intervention to stave off deeper-end, more costly programs or intervention, including juvenile justice or child welfare services.

When a child or youth becomes involved with higher risk programs, frequently stigmas are attached. Common, non-stigmatizing environments to catch beginning signs of needed behavioral health intervention include the school setting, child care settings and primary care doctor offices. These places or systems may have established assessments for behavioral health needs, but many times an interdisciplinary approach is lacking along with assurances for follow-up connections into programs and services post-assessment. Additionally, a primary hub to establish a center for social-emotional wellness at a higher education institution will facilitate better communication on promising behavioral health practices that have supported research and can better inform the workforce on behavioral health practices. This coordinated effort would be an asset for a state as large as Texas.

Why Is This Important?

Addressing behavioral or mental health issues early is critical. Below are several facts that support this concept.

- Mental health problems affect one in every five young people at any given time. (U.S. Department of Health and Human Services).
- Studies indicate that one in five children and adolescents (20 percent) may have a diagnosable disorder. Estimates of the number of children who have mental disorders range from 7.7 million to 12.8 million. (U.S. Department of Health and Human Services).
- Suicide is the third leading cause of death for 15 to 24 year-olds (approx 5,000 young people), and the sixth leading cause of death for 5 to 15 year-olds. (American Academy of Child and Adolescent Psychiatry).
- According to a 1994 federal Office of Juvenile Justice and Delinquency Prevention study of juveniles’ response to health screenings conducted at the admission of juvenile facilities, 73 percent of juveniles reported having mental health problems and 57 percent reported having prior mental health treatment or hospitalization.
- There are cost-benefits to earlier intervention. For example, the cost to the state for one youth who is incarcerated in a Texas Youth Commission (TYC) institution (in 2008) is \$270.49 a day. If behavioral health problems are an issue to the youth’s offense, earlier intervention can save costs to the state, the family and other systems.

- A U.S. Department of Education report stated that schools must shift their focus from *quantity* to *quality* when it comes to the disciplinary and behavioral support methods used. Also encouraged was an increase in the amount of resources allocated to planning and monitoring prevention activities.
- By ensuring families have access to services and knowledge of agencies that provide interventions for behavioral health, children are afforded increased opportunities to remain in a typical public educational setting, to avoid crisis services settings, to have a decreased likelihood of entering the criminal justice setting, and are able to expand upon opportunities for overall success.
- The positive effects of student health and health education on academic performance are supported by much evidence and research.
- Increasing families' access to service areas decreases entries into criminal justice and/or other systems (e.g., entry into the child welfare system, including possible relinquishment of custody issues for lack of behavioral health treatment of the child/youth).
- Services and supports identified as early as possible contribute to the maximization of positive outcomes.
- National and state best practices for serving children and youth with behavioral health service needs have demonstrated that the following values or guiding principles are key to a coordinated service system:
 - Family-Driven/Youth-Guided: the family is the most important and life-long resource in the child's life, as well as being legally and morally responsible for a child. Families will be there long after government services have gone. Therefore, children and youths' plans of care should be driven by the family and (if the youth is old enough), guided by the youth.
 - Community-Based Comprehensive Services and Supports: a broad array of services and supports should be available within the home community to children and families to enable them to respond to biological, neurological, psychological and social issues.
 - Culturally Responsive and Linguistically Competent: services and systems should be responsive to the cultural perspectives and racial, ethnic, cultural and linguistic characteristics of diverse populations served.
 - Individualized Care: services should be individualized to each child and family, guided by a comprehensive, single plan of care for each child and family that addresses strengths as well as problems and needs.
 - Evidence-Based Practices: when state-of-the-art, evidenced-based interventions are available, families should be informed of them, and these interventions should be made available to children and families.

- Coordination: services and systems should be coordinated at the service delivery level, and the agencies and programs that serve children should be linked with those serving adults.
- Early Identification and Intervention: services and supports should emphasize early identification and intervention, as well as prevention of mental health problems, to maximize the likelihood of positive outcomes.
- Accountability: there should be a clear point of responsibility and accountability in measurable terms for children’s mental health care at all levels.

How Is Texas Doing?

Review of the findings of several reports for children and youth in Texas makes the case for earlier intervention for addressing children and youth’s behavioral health needs as soon as possible.

- Based on a 2007 survey report, Raising Texas and the Texas Association of Child Care Resource and Referral Agencies, 60 percent of home-based and center-based providers said that it had been necessary to ask parents to remove a child from their care and/or program due to safety concerns for the child, themselves, the teacher and/or other children.
- The lack of addressing the behavioral health needs of youth in advancing school success has contributed to the fact that one in three juveniles sent to a secure facility operated by TYC has already dropped out of school, and more than 80 percent of Texas adult prison inmates are school dropouts.
- TYC reports that in fiscal year 2009, out of the total number of youth committed, 47 percent were chemically dependent and 37 percent had serious mental health problems.
- The Texas School Survey of Substance Abuse among Students (2008) (full report available at <http://www.dshs.state.tx.us/sa/RecentResearchStudies.shtm>) notes that
 - Forty-five (45) percent of Texas secondary students in 2008 reported using alcohol, tobacco, inhalants, steroids or illicit drugs during the past school year, including the past month; 65 percent reported using some type of substance in their lifetime.
 - The five substances most widely used by young people in Texas were alcohol, tobacco, marijuana, inhalants and powder cocaine.
 - More than one in five 8th graders had a drink in the past month and nearly half of 12th graders were current drinkers.
- A few of the recommendations from the report, *Juvenile Justice, Mental Health and Youth of Color: A Framework for Action in Texas*, (<http://www.swkey.org/news/library.html/title/juvenile-justice-mental-health-and-youth-of-color-a-framework-for-action-in-texas>), included:

- Reform the Texas Education Code disciplinary provisions to take into account mental health issues when school-based disciplinary action is being considered or has been taken. Ensure teachers have training, support and options to work with youth of color displaying behavioral issues without resorting to juvenile justice system involvement.
 - Provide stronger and more effective interventions and supports within the school environment the child attends regularly to prevent students of color who display disruptive behavior from being removed and sent away to inadequate educational alternatives.
 - Expand Texas’ community-based program infrastructure to divert youth of color who have mental health issues but do not pose a public safety threat away from institutional settings. Ensure programs are culturally responsive.
- According to school counselors and school nurses in a recent Texas School-Based Behavioral Health Survey), under the work of the DSHS Mental Health Transformation effort, the overall findings revealed that although there are school and community-based programs that could be accessed or leveraged to provide behavioral health services to school-aged children and their families across the state, many school staff do not know these programs exist, or how to access them. In addition, there is a lack of evident school consensus and/or leadership placing a priority on the provision of behavioral health services and support to school-aged children (ref: http://www.mhtransformation.org/documents/pdf/sbbh/SBBH_Report_FINAL_10.2.09.pdf).
 - “System of Care” service delivery approach has demonstrated positive outcomes, including improved mental health, improved school performance and fewer arrests, according to a national report, *Coordinating Care for Children with Serious Mental Health Challenges: Positive Outcomes for Families, Children, Youth in Systems of Care* (available at: http://www.samhsa.gov/samhsaNewsletter/Volume_17_Number_4/CoordinatingCare2.aspx).
 - Texas has demonstrated this System of Care approach in five communities around the state. (Ref: http://www.hhsc.state.tx.us/tifi/TIFI_SystemCare.html)

Implementation Priorities

- 1) Identify all existing programs within the educational system designed to include the aspect of addressing behavioral health needs in school-aged children and youth [i.e., Coordinated School Health (CSH) model, School Health Advisory Committee (SHAC), Student Assistance Program (SAP), Positive Behavioral Interventions and Supports (PBIS), Response to Intervention (Rtl), Drug Abuse Resistance Education (DARE), Communities in Schools (CIS), etc.].
- 2) Research existing quality reviews that are currently conducted by the TEA to address the availability and efficacy of services provided to children with behavioral health needs in local school districts (i.e., those reviews that document, define and quantify both successful and unsuccessful outcomes of programs or services designed for addressing behavioral health needs of students).

- 3) Through collaboration with the State Advisory Council on Early Childhood Education and Care, identify and evaluate all existing programs within the child care system (Head Start, Early Start, Pre-Kindergarten, etc.) that are designed to include programming for healthy social-emotional development in pre-school aged children. Areas to be evaluated shall include availability, implementation and adherence to evidenced-based programming to meet the needs of enrolled children.
- 4) Explore and review modalities to ensure that children with behavioral health needs who are home-schooled or are educated in charter and private schools have equal access to services through their public school district as do children educated by the public schools.
- 5) Support the establishment of a “Center for Social-Emotional Development” at a higher education institution that serves as a central statewide point for the collection and dissemination of national and state evidence-based and promising practices for children’s mental and behavioral health.

III. Transition

Today’s young people are taking longer to leave home, attain economic independence, and form families of their own than did the same age youth half a century ago. Rather than reaching the milestone of adulthood at age 18 or 21, as happened during the mid-1950s, some young Americans today are well into their 30s before they attain that goal. According to *Transition to Adulthood-The Future of Children* (2010) report, the lengthened transition not only burdens parents who need to be providing for their own retirement, but is also a potent source of social stratification.

As evidenced by research, youth who are successful in transitioning to adulthood have a strong connection to an adult(s) who is interested and committed to that youth’s personal attainment. There is an increased level of support and services required to address transition for those vulnerable youth and their families who are being served within state systems (i.e., youth involved within the foster system, juvenile justice system, mental health system, special education system, or who may be homeless, etc.).

Youth today are technologically savvy and access information differently from past generations, predominantly through social networking sites that have developed significant cultural resonance among them. While particular systems come and go, social networks create new opportunities for youth to grapple with social norms as well as develop the social and technical skills they need to be competent citizens in the digital age.

Today’s service systems need to be adapted toward the social networking skill sets of youth. For example, social networking sites should be included in plans for how youth obtain information on issues of transition to adulthood.



A responsive system to meet the transition need of these young people will cultivate healthier and more productive citizens of society.

Why Is This Important?

An essential factor for success is when a youth is connected to a local community in positive and productive ways. Having a strong connection to a local school (a non-stigmatizing environment) is an essential factor in receiving information. A ‘well-connected’ youth is more successful during transition to adulthood (costs are less, returns on investment are higher). Mentoring and case management are two related program strategies that are associated with positive education and career outcomes. Both mentoring and case management provide youth with individualized support and aid from caring adults.

Frequently various youth service systems are so focused on exiting youth out of their systems that gaps in safety nets are being missed; many individuals are being lost in transition, and individuals are being forced out of systems without long-term plans for support or outcomes. Youth transition plans should begin with long-term outcomes in mind. All youth, not just youth with disabilities, need to be prepared whether through higher education, vocational education, etc.

Several reports and research listed below confirm the needs and potential interventions of youth moving toward successful adulthood.

- Ready By 21 (National): <http://www.forumforyouthinvestment.org/readyby21>
- Outcome data: http://forumfyi.org/files/Data_Statement_Nov_2009.pdf
- “States that are Making It Work” http://forumfyi.org/files/DQCbrief_Mar19_FINAL.pdf
- Insulating the Education Pipeline: <http://www.forumforyouthinvestment.org/content/insulating-education-pipeline-increase-postsecondary-success>
- http://www.childtrends.org/Files//Child_Trends-2010_03_09_FS_WWOlderYouth.pdf
- http://www.brookings.edu/events/2010/0427_adolescence.aspx
- <http://www.futureofchildren.org/>
- The Network on Transitions to Adulthood -MacArthur Foundation Funded: <http://www.transad.pop.upenn.edu/>

- National Network on Youth Transition for Behavioral Health: <http://nnyt.fmhi.usf.edu/>
- Vulnerable Youth and the Transition to Adulthood: http://www.urban.org/uploadedpdf/411948_distressed_neighborhoods.pdf and <http://aspe.hhs.gov/hsp/09/vulnerableyouth/index.shtml>
- The Difficult Transition to Adulthood for Foster Youth: http://www.srcd.org/index.php?option=com_docman&task=doc_download&gid=469&Itemid=99999999
- Supporting Youth in Transition to Adulthood: Lessons Learned from Child Welfare and Juvenile Justice: <http://www.dupontfund.org/learning/pdfs/supporting-youth-transitions-adulthood.pdf>
- Transition to Independence Process (TIP)/The National Center on Youth Transition: http://tip.fmhi.usf.edu/tip.cfm?page_ID=3
- Transition Resource Directory: http://www.findyouthinfo.gov/topic_transition_resourceDirectory.shtml

How Is Texas Doing?

Texas does not have a responsive and seamless system for young adults, or their families, to successfully transition to adulthood. A responsive and seamless system would support the following features:

- available 24 hours a day, 7 days a week;
- provide accurate information for a youth interested in higher education or training, or entering the workforce; and
- provide service navigation as needed and/or requested.

Connectivity to families and/or communities should be developed for all youth before they leave high school. Stronger safety nets need to be developed and implemented especially for vulnerable youth (i.e., youth in juvenile justice or foster care systems). For example, DARS has been very focused on the early development of life skills with its clients, rather than waiting until the last year of high school to begin the process. Additionally, foster children are now receiving transitional life skills at age 14 rather than at age 16.

Below are a few examples of reports, initiatives and suggestions that address young people in Texas transitioning to adulthood.

- Ready By 21 in Austin, Texas: <http://readyby21austin.org/> [initiated and supported under the auspices of the Workforce Investment Act (WIA)].
- H.B. 1230 Transition Report: http://www.hhsc.state.tx.us/reports/HB1230_0509.pdf
- H.B. 1912 Transition Workgroup Report: http://www.dfps.state.tx.us/documents/Child_Protection/pdf/2010-09-03_Transitional_Living_Services_Plan.pdf

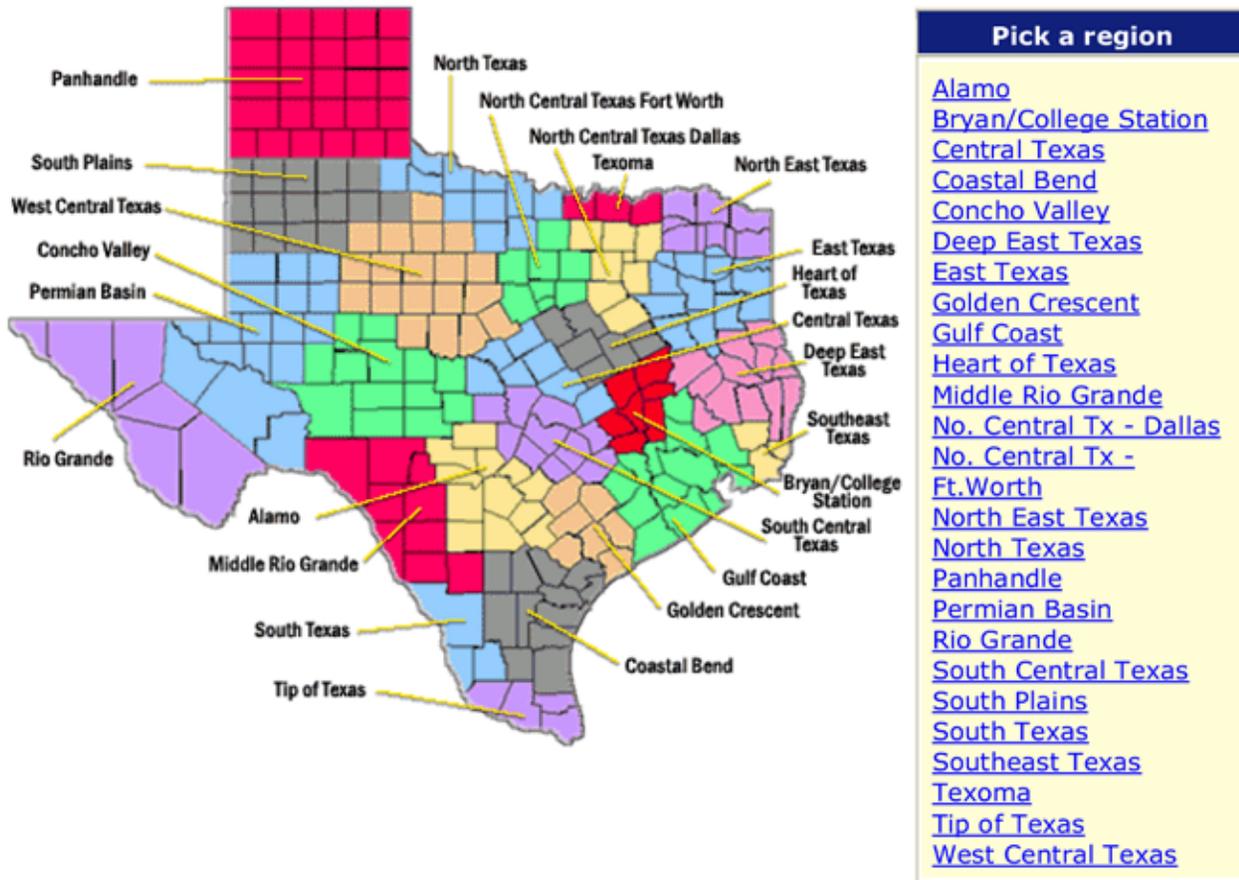
Implementation Priorities

- 1) Identify essential programmatic elements for an ideal cross-systems approach of revenue-neutral transitional services and supports, to serve as the foundational building blocks for all young people and their families.
- 2) Identify gaps and model programs (i.e., existing regional transition centers for youth aging out of foster care, vocational rehabilitation transition specialists in schools, model peer mentor programs, etc.) that address transitional services and supports within Texas that are evidenced-informed (i.e., documents, defines and quantifies both successful and unsuccessful outcomes of transition to adulthood services) for youth and families in Texas. Assess whether these programs address:
 - a) long-term positive growth outcomes, including connections with adults, increase high school completion rates, etc.;
 - b) practices that strengthen natural support systems; and
 - c) safety nets being in place when youth stop services or systems fail.
- 3) Identify the capacity and abilities of Texas state agencies to access and provide service information on social networking sites, and in particular of the Texas 211 System to incorporate an enhanced social networking information and referral component or “clearinghouse” targeted to young persons and their families seeking transitional services and support. Identify strategies to support the work of the Texas 211 System to measure and address gaps in the service system that could be addressed by (revenue-neutral) collaborations with Council member agencies. Use this information to develop a seamless “Foundation for Transition to Adulthood Clearinghouse” within or external to the Texas 211 system, that features a menu of current services and supports that are positive, strength-based, culturally and linguistically appropriate and user-friendly, and initiate a statewide public awareness initiative to connect families and youth to the clearinghouse.



Finding Help In Texas

A program of the Texas Health and Human Services Commission



demonstration cross-system training program for staff who can assist all young people in addition to those vulnerable populations of youth in transition.

IV. Fiscal Opportunities

With consideration for the current budget challenges faced by the state, the Council proposes that Texas prioritize investments within revenue neutral parameters targeting the following areas:

Early Childhood Intervention

Leverage other services in the Texas system to maximize resources available to Early Childhood Intervention (ECI, birth to age three) children.

Behavioral Health/Mental Health/Substance Abuse

- **Integrated Mental Health**
Support the Frew Strategic Initiative 'SUPPORT,' using a behavioral health specialist in an integrated medical setting. This model is being tested in five pilot sites. Early indications are that this model has successful outcomes and may result in lower utilization of medications and other, higher cost treatments.
- **Mental Health Funding Initiative**
Support the efforts of the Children's Coordinating Funding Committee; this committee, under the mental health transformation grant, is looking at more efficient ways to fund services for children and youth with severe emotional disturbances and their families. DSHS is the lead agency on the mental health transformation grant and will be working with the University of Texas (UT) in this effort.
- **Substance Abuse Funding Initiative**
Leverage the DSHS UT contract to expand the revenue maximization for substance abuse treatment for children in the foster care system. Funding is to come from HHSC for the study. Screen pregnant women and mothers of infants using evidence-based tools, such as the 4P's Plus Screen for Substance Use in Pregnancy, followed by appropriate interventions. This can be done through existing state programs such as the Texas Nurse-Family Partnership.
- **Brain Injury Federal Initiative**
Endorse the Health Resources and Services Administration (HRSA) funded Juvenile Justice/ Office of Acquired Brain Injury initiative to screen youth in the juvenile justice system for brain injury. The pilot screens for brain injury and provides training in the most effective cognitive/behavioral therapy for youth identified as with these injuries.

Support the model being considered for the TEA regional Education Service Centers initiative that includes increasing behavioral health focused training and technical assistance opportunities available to local independent school districts through a regional school health specialist in addition to their traditional physical health related activities.
- **Education Initiative**
Ensure information on best practices for behavioral health is available to schools and teachers.

For the 2010-2011 school year, the district lead for school counselors will receive training from TEA staff on behavioral/mental health. Explore having continuing education available on behavioral health management.

Transition

Review H.B. 1230 workgroup recommendations from the 80th Legislature that are low cost.



CONCLUSION

The Council has scheduled a work session for January 2011 to further develop its strategic vision, goals and action plan for the priority issue areas outline in this report, including but not limited to the identification and establishment of timelines, outcomes, benchmarks, and responsible parties.

Through the regional leadership councils, local agency and community leaders from across multiple sectors will come together to develop a coordinated local response to the needs of children and families that is built upon the unique strengths, assets and resources of the community. With this regional infrastructure, the Council will be able to establish a clear line of communication from communities, providing state decision-makers with better information from which to develop policy and practices. Additionally, the Council will be able to identify and recognize promising practices and areas of excellence from the smallest to the largest communities in Texas, and promote the replication of local programs as appropriate and within current resources in other communities in the state.

A critical review by the Council of the existing state level workgroups, committees and councils to propose a more efficient cross agency system that better utilizes the time and effort of public servants and additional stakeholders will create effective partnerships to serve the children and families in Texas. There is much talent and expertise within public and private providers, as well as the people who are served and advocacy organizations. Guiding this collective energy in a method that is streamlined and clear to all, will serve Texas well. “Promoting healthy children and strengthening families” are worthwhile goals of the Council on Children and Families and of the families and systems the Council represents.



APPENDICES

Appendix A - Texas Government Code Section 531.801

Appendix B - Council on Children and Families Membership Roster

Appendix C - Biennial Legislative Appropriations Request Analysis Report - May 1, 2010

Appendix D - Children's Interagency Workgroups Inventory

Appendix E - Regional Maps

Appendix F - Purpose for Regional Councils on Children and Families

Texas Government Code Section 531.801

Sec. 531.801. DEFINITION. In this subchapter, “council” means the Council on Children and Families.

Added by Acts 2009, 81st Leg., R.S., Ch. 819, Sec. 1, eff. June 19, 2009.

Sec. 531.802. COUNCIL ON CHILDREN AND FAMILIES.

- (a) The Council on Children and Families is established to:
 - (1) coordinate the state’s health, education, and human services systems to ensure that children and families have access to needed services;
 - (2) improve coordination and efficiency in state agencies, advisory councils on issues affecting children, and local levels of service;
 - (3) prioritize and mobilize resources for children; and
 - (4) facilitate an integrated approach to providing services for children and youth.
- (b) The council shall:
 - (1) promote a common vision of desired outcomes for children and youth and of family and community supports;
 - (2) promote shared accountability for outcomes for children and youth; and
 - (3) align allocations of resources with policies for children and youth.
- (c) Subject to Subsection (d), the council is composed of the following:
 - (1) the executive commissioner;
 - (2) the commissioner of state health services;
 - (3) the commissioner of the Department of Family and Protective Services;
 - (4) the commissioner of aging and disability services;
 - (5) the commissioner of assistive and rehabilitative services;
 - (6) the commissioner of education;
 - (7) the executive director of the Texas Juvenile Probation Commission;
 - (8) the executive commissioner of the Texas Youth Commission;
 - (9) the executive director of the Texas Workforce Commission;
 - (10) the director of the Texas Correctional Office on Offenders with Medical or Mental Impairments;
 - (11) two public representatives who are parents of children who have received services from an agency represented on the council, appointed by the executive commissioner; and
 - (12) two representatives who are young adults or adolescents who have received services from an agency represented on the council, appointed by the executive commissioner.
- (d) An individual listed in Subsections (c)(1)-(10) may designate another individual as having authority to act on behalf of the individual at council meetings and with respect to council functions.
- (e) The members of the council annually shall elect one member to serve as the presiding officer.

- (f) Council meetings are held at the call of the presiding officer.
- (g) The council is administratively attached to the commission but is independent of direction by the commission or the executive commissioner. The commission, through the commission's Office of Program Coordination for Children and Youth, shall provide administrative support and resources to the council as necessary to enable the council to perform its duties.
- (h) The agencies represented on the council shall provide periodic staff support of specialists as needed to the council.
- (i) The council is not subject to Chapter 2110.

Added by Acts 2009, 81st Leg., R.S., Ch. 819, Sec. 1, eff. June 19, 2009.

Sec. 531.803. DUTIES.

- (a) The council shall:
 - (1) analyze the biennial legislative appropriations requests of members of the council for services provided to children and their families and identify appropriations that, through the coordination of members of the council, could be modified in the next legislative appropriation request to eliminate waste or increase available services and, not later than May 1 of each even-numbered year, prepare a report recommending those modifications for consideration during the development of the next biennial legislative appropriations request;
 - (2) investigate opportunities to increase flexible funding for health, education, and human services provided to children and their families;
 - (3) identify methods to remove barriers to local coordination of health, education, and human services provided to children and their families;
 - (4) identify methods to ensure that children and youth receive appropriate assessment, diagnoses, and intervention services;
 - (5) develop methods to prevent unnecessary parental relinquishment of custody of children;
 - (6) prioritize assisting children in family settings rather than institutional settings; and
 - (7) make recommendations about family involvement in the provision and planning of health, education, and human services for a child, including family partner and liaison models.
- (b) The state agency members of the council may, as appropriate, enter into memoranda of understanding with other agencies to implement any method, process, policy, or recommendation identified or developed under Subsection (a). Before a method, process, policy, or recommendation is implemented, the council shall:
 - (1) identify:
 - (A) the timeline and proposed outcome of implementing the method, process, policy, or recommendation; and
 - (B) benchmarks that may be used to measure the success of the implementation of the method, process, policy, or recommendation; and

- (2) assign to the appropriate members of the council responsibility for implementing the method, process, policy, or recommendation.
- (c) The council may collect data necessary to conduct the council's duties or implement the council's recommendations and shall use any reports or information produced by other entities related to children, youth, and families to inform the council.

Added by Acts 2009, 81st Leg., R.S., Ch. 819, Sec. 1, eff. June 19, 2009.

Sec. 531.804. REPORT BY COUNCIL REGARDING CHILD WELFARE. Not later than December 1 of each even-numbered year, the council shall submit a report to the governor, lieutenant governor, speaker of the house of representatives, and members of the legislature that contains:

- (1) the requests, plans, and recommendations of the council, including recommendations of any legislation that is needed to further develop and maintain a statewide system of quality health, education, and human services for children and families; and
- (2) information regarding the implementation by the members of the council of any method, process, policy, or recommendation, including information regarding whether the implementation has proceeded in accordance with the timeline, outcome, and benchmarks identified by the council.

Added by Acts 2009, 81st Leg., R.S., Ch. 819, Sec. 1, eff. June 19, 2009.

Sec. 531.805. SUNSET PROVISION. The Council on Children and Families is subject to Chapter 325 (Texas Sunset Act). Unless continued in existence as provided by that chapter, the council is abolished and this subchapter expires September 1, 2019.

Added by Acts 2009, 81st Leg., R.S., Ch. 819, Sec. 1, eff. June 19, 2009.

Council and Children Families Membership Roster

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Biennial Legislative Appropriations Request Analysis Report - May 1, 2010

Introduction

The Texas Council on Children and Families is a newly formed interagency Council created in accordance with the Texas Government Code Section 531.801 convening the first meeting on September 30, 2009. The Council is established to:

- coordinate the state's health, education, and human services systems to ensure that children and families have access to needed services;
- improve coordination and efficiency in state agencies, advisory councils on issues affecting children, and local levels of service;
- prioritize and mobilize resources for children; and
- facilitate an integrated approach to providing services for children and youth.

The membership on the Council (see Appendix A) is composed of executive leadership from health and human service agencies, juvenile justice agencies, the central education agency, the workforce commission, and representatives from the public as follows:

- the Executive Commissioner of the Texas Health and Human Services Commission;
- the Commissioner of the Department of State Health Services;
- the Commissioner of the Department of Family and Protective Services;
- the Commissioner of the Department of Aging and Disability Services;
- the Commissioner of the Department of Assistive and Rehabilitative Services;
- the Commissioner of the Texas Education Agency;
- the Executive Director of the Texas Juvenile Probation Commission;
- the Executive Commissioner of the Texas Youth Commission;
- the Executive Director of the Texas Workforce Commission;
- the Director of the Texas Correctional Office on Offenders with Medical or Mental Impairments;
- two public representatives who are parents of children who have received services from an agency represented on the Council, appointed by the Texas Health and Human Services Executive Commissioner; and
- two representatives who are young adults or adolescents who have received services from an agency represented on the Council, appointed by the Texas Health and Human Services Executive Commissioner.

The Council is administratively attached to the Texas Health and Human Services Commission but is independent in direction. Council members have determined an infrastructure through approving operational guidelines and electing leadership.

Council's Charge

One of the requirements of the Council is to analyze the biennial legislative appropriations requests (LARs) of Council member agencies for services provided to children and their families not later than May 1 of each of the even-numbered years, and prepare a report. This document serves as that report.

The report is to identify appropriations that, through the coordination of members of the Council, could be modified in the next legislative appropriations request to eliminate waste or increase available services and recommend those modifications for consideration during the development of the next biennial legislative appropriations request. Additionally, through the analysis of the member agency's biennial LAR, the Council shall:

- Investigate opportunities to increase flexible funding for health, education, and human services provided to children and their families;
- Identify methods to remove barriers to local coordination of health, education, and human services provided to children and their families;
- Identify methods to ensure that children and youth receive appropriate assessment, diagnoses, and intervention services;
- Develop methods to prevent unnecessary parental relinquishment of custody of children;
- Prioritize assisting children in family settings rather than institutional settings; and
- Make recommendations about family involvement in the provision and planning of health, education, and human services for a child, including family partner and liaison models.

Accomplishments to Date

Within the seven months since the first meeting of the Council, members have worked towards developing effective strategies to meet the requirements as statutorily charged. An inventory of the state's interagency workgroups was developed and assessed into eight categories:

- Early Childhood Detection and Intervention
- Education
- Health Care
- Long-Term Community-Based Services and Support
- Mental Health
- Juvenile Justice
- Transition Issues, and
- Crisis Prevention and Intervention

These eight categories became the basis for how the Council chose to list budget strategies in developing a template for the compilation of data from fiscal year 2010 operating budget and fiscal year 2011 appropriation. An additional ninth category of "other" was included to allow for budget items targeting children and families that may not align into the eight identified categories.

Council members used another strategy to determine issue areas of interest or populations of interest that this newly formed Council may address in order to improve outcomes for children and families. Individual Council members submitted information on these areas of interest for consideration. The results were tabulated and the most frequent issue areas identified in ascending order are:

- Mental Health or Behavioral Health
- Early Childhood Intervention, and
- Transition Issues.

The Council has also discussed the importance and commitment to obtain feedback from community service providers, in addition to the input provided from family and youth representatives on the Council and from public testimony at Council meetings as they move forward toward their work as a collaborative Council. Additionally, the Council is actively learning about various successful family partner and family liaison models in identifying assets within the state in addition to issue or problem areas.

Recommendations Based Upon the Biennial Legislative Appropriations Requests Analysis

As a result of the Council's work to date, the following are recommendations related to data collected from fiscal years 2010 and 2011.

- Recommend that data collected from fiscal years 2010 and 2011 in the proposed format of nine categories serve as baseline data for subsequent biennial LAR analysis reports as comparisons and as the basis for further analysis. See fiscal information below and in Appendix B.
- Recommend that the fiscal data from the top three issue areas serve as initial target areas for the Council to further analyze and inform substantive recommendations.
 - Mental / Behavioral Health Services,
 - Early Childhood / Early Childhood Interventions, and
 - Transition Issues.
- Recommend a template for further analysis of the LAR data in the three above targeted areas.

Conclusion

The Council plans to use this baseline analysis to continue to review agencies' fiscal data and include updates from agencies' final approved LARs for fiscal years 2012 and 2013. This data will be further updated to reflect fiscal amounts that include the approved five percent agency budget reductions. Additionally, the Council may refine the fiscal reporting information as ongoing analysis are conducted to more suitably organize the information, and therefore, formulate broader recommendations.

The Council intends to use this baseline fiscal data and include programmatic information to expand their recommendations. The Council will also determine timelines; proposed outcomes of implementing a method, process, policy, or recommendation; and include benchmarks that may be used to measure the success of the implementation of the method, process, policy, or recommendation.

The Council is poised to implement a data-driven decision-making approach to effectively improve and coordinate the state's health, education, and human services systems to ensure that children and families have access to needed services.

Early Childhood Detection & Interventions:

Agency	Strategy			
DARS	A.1.1 ECI Services A.1.2 ECI Respite Services A.1.3 Ensure Quality ECI Services			
HHSC	A.1.1.10 Enterprise Oversight and Policy: Nurse Family Partnership			
Early Childhood Detection & Interventions Totals				
FY	General Revenue	Federal Funds	Other	All Funds
2010*	\$36,213,162	\$139,314,820	\$16,551,331	\$192,079,313
2011*	\$36,213,162	\$139,314,820	\$16,551,331	\$192,079,313

Education:

Agency	Strategy			
TYC	B.1.1 Education and Workforce Programs (DAMS)			
DSHS	B.2.6 Develop a Statewide Program to Reduce the Use of Tobacco Products: Youth Prevention B.2.6 Develop a Statewide Program to Reduce the Use of Tobacco Products: Smokeless Tobacco			
TEA	A.1.1 Foundation School Program - Equalized Operations A.1.2 Foundation School Program - Equalized Facilities A.2.1 Statewide Educational Programs A.2.2 Achievement of Students at Risk A.2.3 Students with Disabilities A.2.4 School Improvement & Support Programs A.2.5 Adult Education and Family Literacy B.2.1 Technology and Instructional Materials B.2.4 Windham School District B.3.1 Improving Educator Quality and Leadership B.2.2 Health and Safety B.2.3 Child Nutrition Programs			
Education Totals				
FY	General Revenue	Federal Funds	Other	All Funds
2010*	\$13,391,549,511	\$8,378,460,708	\$4,114,173,566	\$25,884,183,785
2011*	\$13,391,549,511	\$8,378,460,708	\$4,114,173,566	\$25,884,183,785

Healthcare:

Agency	Strategy			
TYC	A.1.5. - Health Care Services A.1.7. - Health Care Oversight			
HHSC	A.1.1. Enterprise Oversight and Policy: A.1.1.1; A.1.1.2; A.1.1.3 A.1.1.5 Enterprise Oversight and Policy: Umbilical Cord Blood Bank A.1.1.6 Enterprise Oversight and Policy: Border Relations A.1.1.8 Enterprise Oversight and Policy: Office for the Elimination of Health Disparities (OEHD) B.1.1 Medicare and Supplemental Security Income Risk Groups B.1.2 TANF Adults and Children B.1.2.1 TANF Adults and Children: STAR Health B.1.3 Pregnant Women Risk Group B.1.4 Children & Medically Needy Risk Group B.1.5 Medicare Payments - Clients Dually Eligible for Medicare and Medicaid B.1.6 Star+PLUS B.2.1 Cost Reimbursement Services B.2.2 Medicaid Vendor Drug Program B.2.4 Medical Transportation B.2.5 Medicaid Family Planning B.3.1 Health Steps (EPSDT) Medical B.3.2 Health Steps (EPSDT) Dental B.3.3 Health Steps (EPSDT) Comprehensive Care Program C.1.1 Children's Health Insurance Program (CHIP) C.1.2. Immigrant Children Health Insurance C.1.3 School Employee Children Insurance C.1.4 CHIP Perinatal Services C.1.5 CHIP Vendor Drug Program D.1.1 TANF D.1.2 Refugee Assistance D.2.1 Family Violence Services D.2.2 Alternatives to Abortion			
DSHS	A.3.4 Children with Special Health Care Needs B.1.1 Provide WIC Services B.1.2 Women and Children's Health Services: Health & Social Services for children B.1.2 Women and Children's Health Services: Population Based Services B.1.2 Women and Children's Health Services: Dental Services B.1.2 Women and Children's Health Services: Women & children - other B.1.4 Community Primary Care Services B.1.3 Family Planning Services			
Healthcare Totals				
FY	General Revenue	Federal Funds	Other	All Funds
2010*	\$5,919,898,235	\$13,166,096,730	\$20,838,089	\$19,106,833,054
2011*	\$6,983,232,925	\$10,762,023,881	\$20,837,744	\$17,766,094,550

Long-term Community Based Services & Support:

Agency	Strategy			
DADS	A.2.2 Community Attendant Services A.3.2 Home and Community-Based Services A.3.3 Community Living Assistance (CLASS) A.3.5 Medically Dependent Children PGM A.3.6 Consolidated Waiver Program A.3.7 Texas Home Living Waiver A.4.2 MR Community Services A.4.4 In-Home and Family Support A.4.5 Mental Retardation In-Home Services A.6.1 Nursing Facility Payments A.7.1 Intermediate Care Facilities - MR A.8.1 MR State Schools Services			
Long-term Community Based Services & Support Totals				
FY	General Revenue	Federal Funds	Other	All Funds
2010*	\$1,466,217,469	\$3,096,959,759	\$26,889,843	\$4,590,067,071
2011*	\$1,825,024,611	\$2,936,272,103	\$41,543	\$4,761,338,257

Mental Health:

Agency	Strategy			
TJPC	B. 1.1 Community Corrections Services B.1.1 Community Corrections Services: The Commitment Reduction Program B.1.4 Special Needs Diversionary Programs			
TYC	A.1.6 Mental Health Services			
HHSC	A.1.1.7 Enterprise Oversight and Policy: Office of Acquired Brain Injury			
DSHS	B.2.2 Mental Health Services for Children B.2.3 Community Mental Health Crisis Services: Transitional MH Services for children B.2.3 Community Mental Health Crisis Services: Intensive Ongoing MH Services for children B.2.4 NorthSTAR Behavioral Health Waiver B.2.5 Substance Abuse Prevention, Intervention and Treatment: Substance Abuse Prevention B.2.5 Substance Abuse Prevention, Intervention and Treatment: Substance Abuse Treatment C.1.3 Mental Health State Hospitals: Waco Center for Youth – MH Residential Facility C.1.3 Mental Health State Hospitals: State MH Hospital –Child and Adolescent Unit			
Mental Health Totals				
FY	General Revenue	Federal Funds	Other	All Funds
2010*	\$87,212,056	\$84,352,681	\$7,566,422	\$179,131,159
2011*	\$86,394,544	\$80,276,035	\$8,657,260	\$175,327,839

Juvenile Justice:

Agency	Strategy			
TJPC	A.1.1 Basic Probation Services B.1.1.1 Community Corrections Services: Community Corrections Services B.1.1.2 Community Corrections Services: The Secure Felony Placement Fund B.1.1.3 Community Corrections Services: The Commitment Reduction Program B.1.1.5 Community Corrections Services: the Diversionary Fund Grant B.1.1.6 Community Corrections Services: the Intensive Community Based Program			
TYC	A.1.2 Institutional Services A.1.3 Contracted Capacity A.1.4 Halfway House Services			
TDCJ	B.1.1 Special Needs Projects			
Juvenile Justice Totals				
FY	General Revenue	Federal Funds	Other	All Funds
2010*	\$253,847,164	\$7,318,083	\$0	\$261,165,247
2011*	\$266,362,669	\$6,421,475	\$0	\$272,784,144

Transition:

Agency	Strategy			
DARS	B.3.1 Vocational Rehabilitation -General B.1.3 Vocational Rehabilitation for persons who are blind or visually impaired			
TYC	C.1.3 Parole Services C.1.3 Parole Services: MST and FFT C.1.3 Parole Services: CARE grant			
Transition Totals				
FY	General Revenue	Federal Funds	Other	All Funds
2010*	\$11,521,968	\$8,327,679	\$0	\$22,755,511
2011*	\$11,682,931	\$8,327,679	\$0	\$20,010,610

Crisis Prevention & Intervention:

Agency	Strategy			
HHSC	A.1.1.4 Enterprise Oversight and Policy: Sub-strategy: TIFI A.1.1.4 Enterprise Oversight and Policy: Sub-strategy: CRCG Adult/Children A.1.1.9 Enterprise Oversight and Policy: Texas Office for the Prevention of Developmental Disabilities A.1.2.8 Integrated Eligibility and Enrollment Sub-strategy: Healthy Marriage			

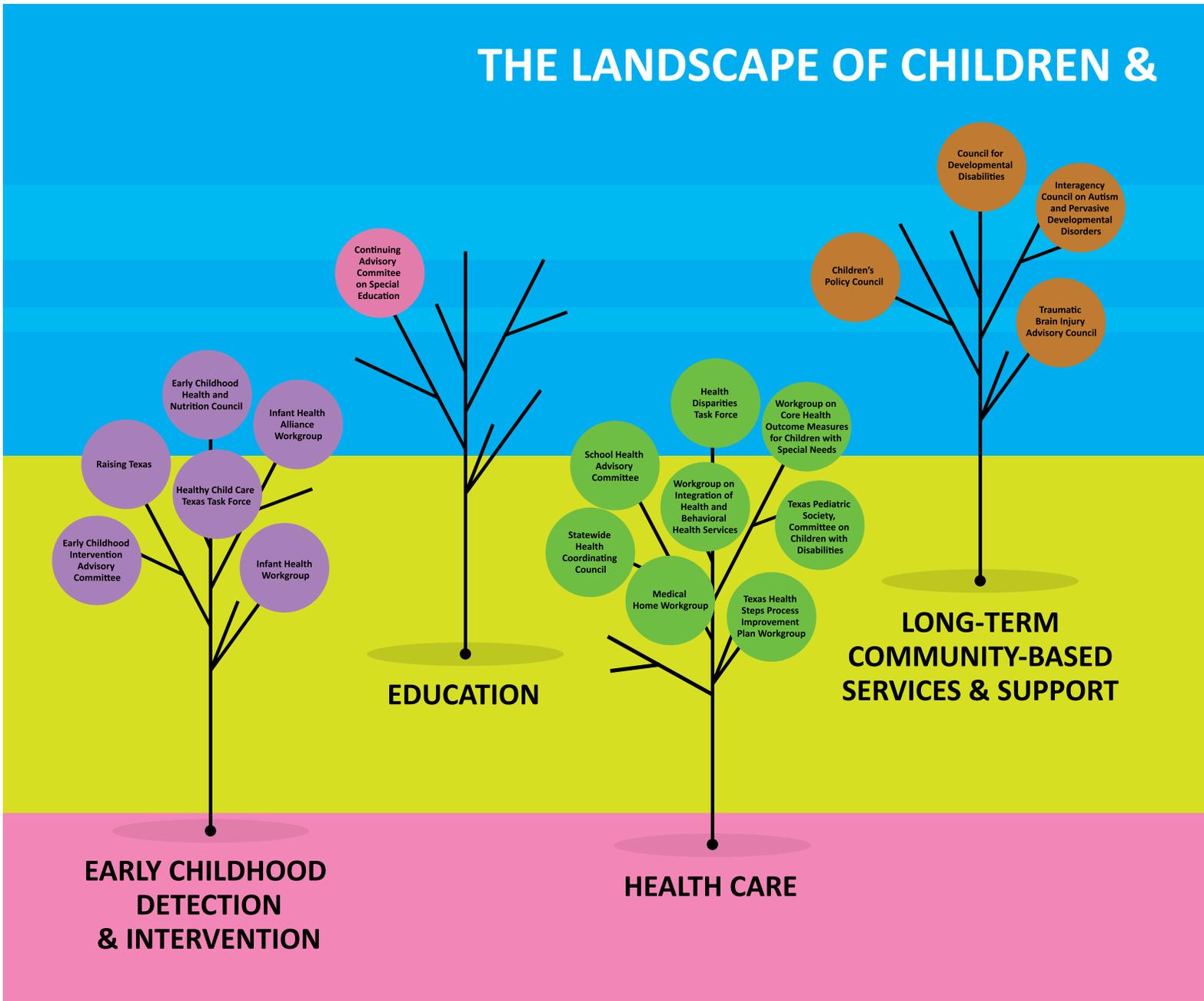
DFPS	A.1.1	Statewide Intake Services		
	B.1.1	CPS Direct Delivery Staff		
	B.1.2	CPS Program Support		
	B.1.3	TWC Foster Day Care		
	B.1.4	TWC Relative Day Care		
	B.1.5	TWC Protective Day Care		
	B.1.6	Adoption Purchased Services		
	B.1.7	Post-adoption purchased		
	B.1.8	Pal Purchased Services		
	B.1.9	Substance Abused Purchased		
	B.1.10	Other CPS Purchased Services		
	B.1.11	Foster Care Payments		
	B.1.12	Adoption Subsidy payments		
	C.1.1	Star Program		
	C.1.2	CYD Program		
	C.1.3	Texas Families Program		
	C.1.4	Child Abuse Prevention Grants		
C.1.5	Other at-risk prevention			
C.1.6	At-Risk Prevention Program			
Crisis Prevention & Intervention Totals				
FY	General Revenue	Federal Funds	Other	All Funds
2010*	\$448,520,342	\$780,317,292	\$13,322,991	\$1,242,160,625
2011*	\$448,520,342	\$780,317,292	\$13,322,991	\$1,242,160,625

Other Core Services Related to Children & Families Not Covered in Any Other Category:

Agency	Strategy			
DARS	A.2.1 Habilitative Services for Children			
	A.3.1 Autism Program			
HHSC	A.1.2.1 Integrated Eligibility and Enrollment Sub-strategy: 2-1-1			
	A.1.2 Integrated Eligibility and Enrollment			
DFPS	E.1.1 Child Care Regulation			
TWC	A.1.2 Workforce Investment Act (WIA) Youth			
	A.3.1 TANF Choices Child Care			
	A.3.2 Transitional Child Care			
	A.3.3 At-Risk Child Care			
Other Core Services Related to Children & Families Not Covered in Any Other Category Totals				
FY	General Revenue	Federal Funds	Other	All Funds
2010*	\$422,995,385	\$876,749,926	\$15,088,431	\$1,314,833,742
2011*	\$422,975,747	\$881,184,409	\$15,088,431	\$1,319,248,587

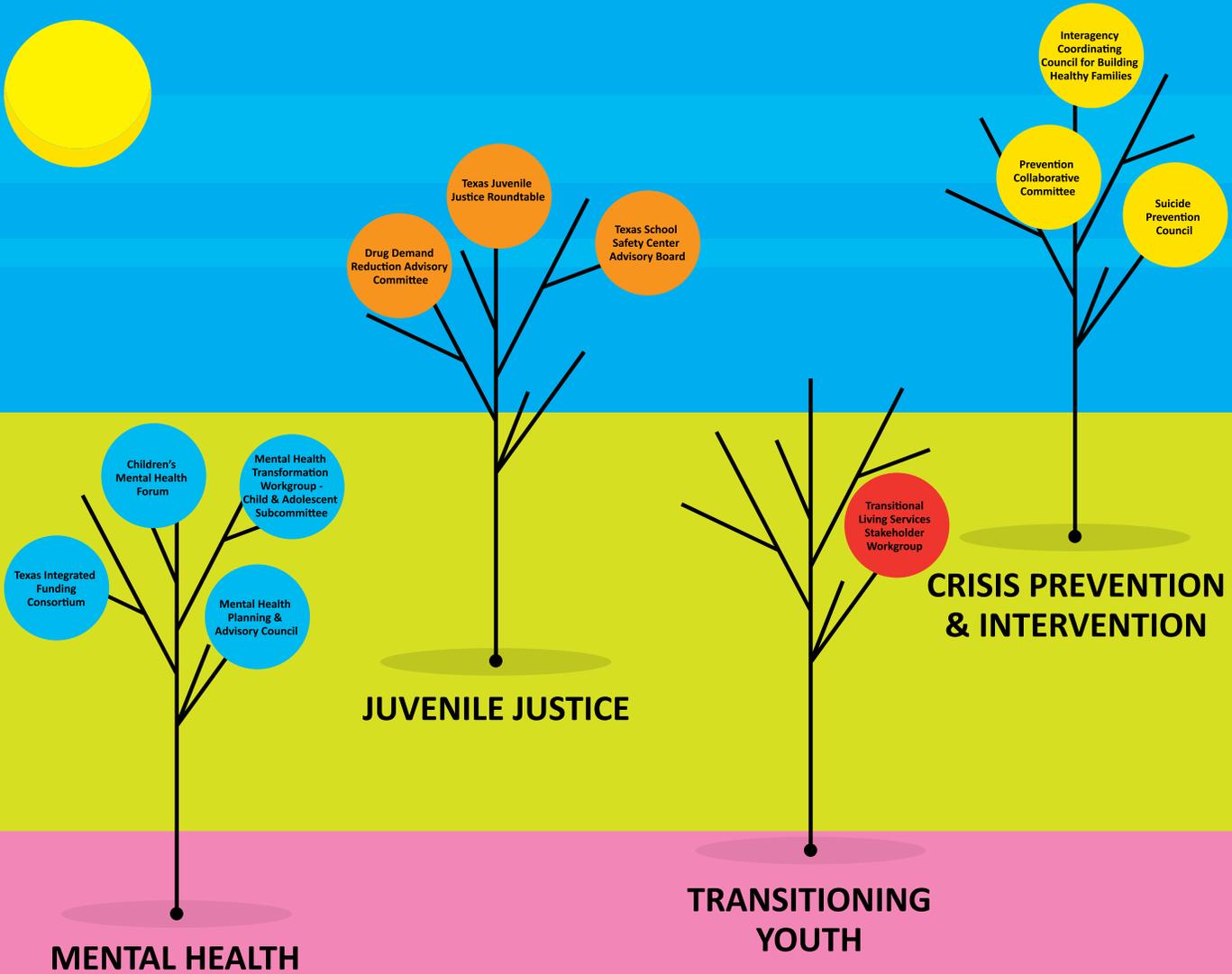
*These values do not account for the FY10 and FY11 5% budget reduction; those values will be updated at a later time.

THE LANDSCAPE OF CHILDREN &



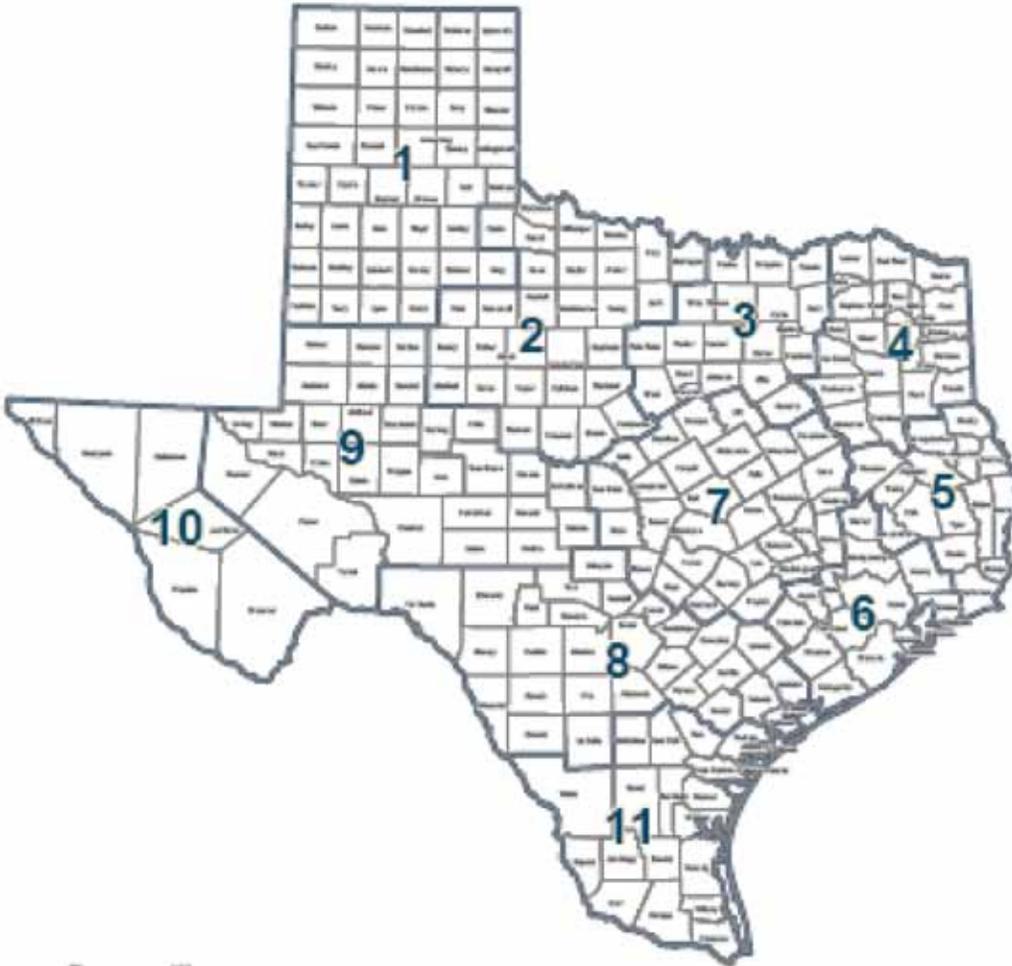
Note that some groups serve the purpose of two or more categories, for example the School Health Advisory Committee can be categorized under the Health topic and the Education topic.

YOUTH STATE INTERAGENCY COMMITTEES



Regional Maps

TEXAS HEALTH AND HUMAN SERVICES COMMISSION HHS Regions



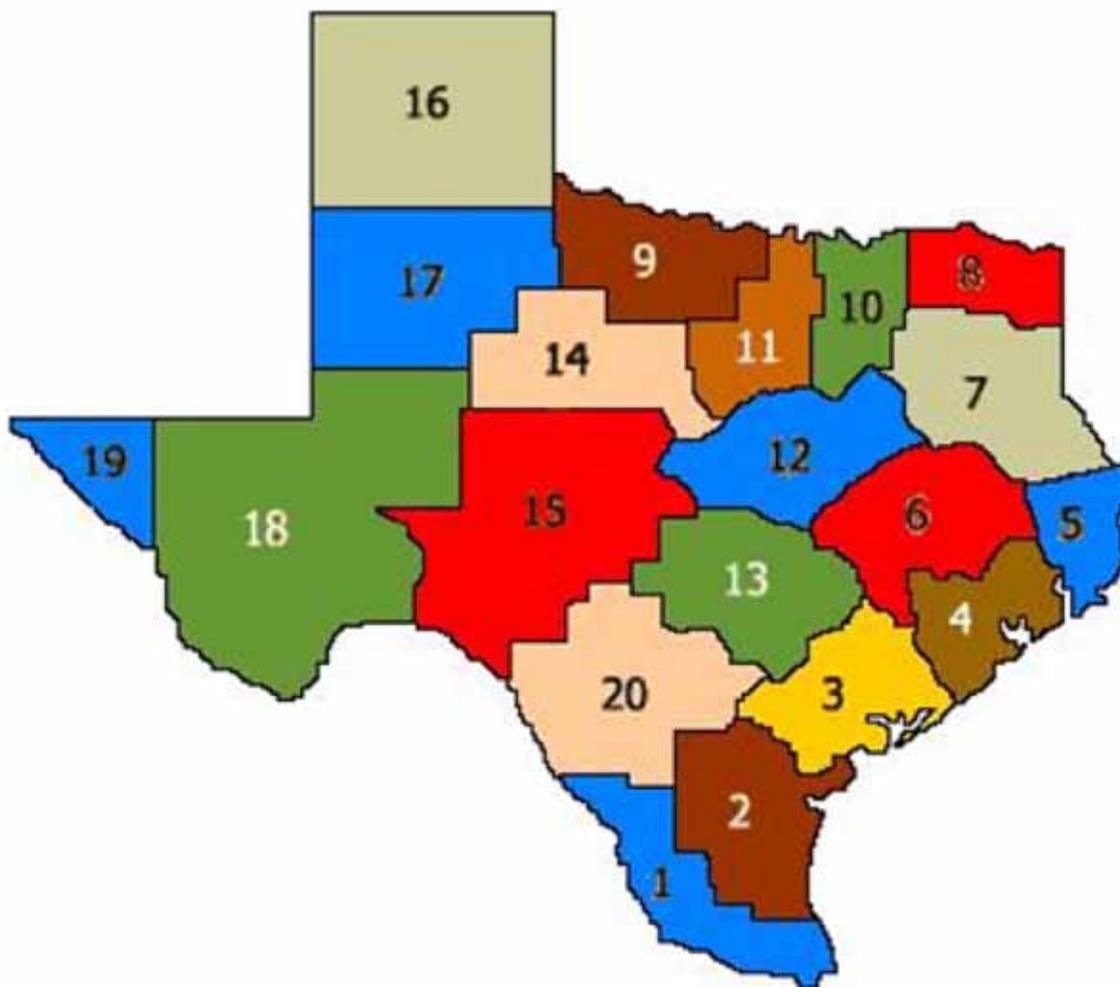
HHS Regions:

- Region 1 - High Plains
- Region 2 - Northwest Texas
- Region 3 - Metroplex
- Region 4 - Upper East Texas
- Region 5 - Southeast Texas
- Region 6 - Gulf Coast
- Region 7 - Central Texas
- Region 8 - Upper South Texas
- Region 9 - West Texas
- Region 10 - Upper Rio Grande
- Region 11 - Lower South Texas



Map Prepared by AHDC, Strategic Decision Support
July 26, 2010

TEXAS EDUCATION AGENCY Education Service Centers

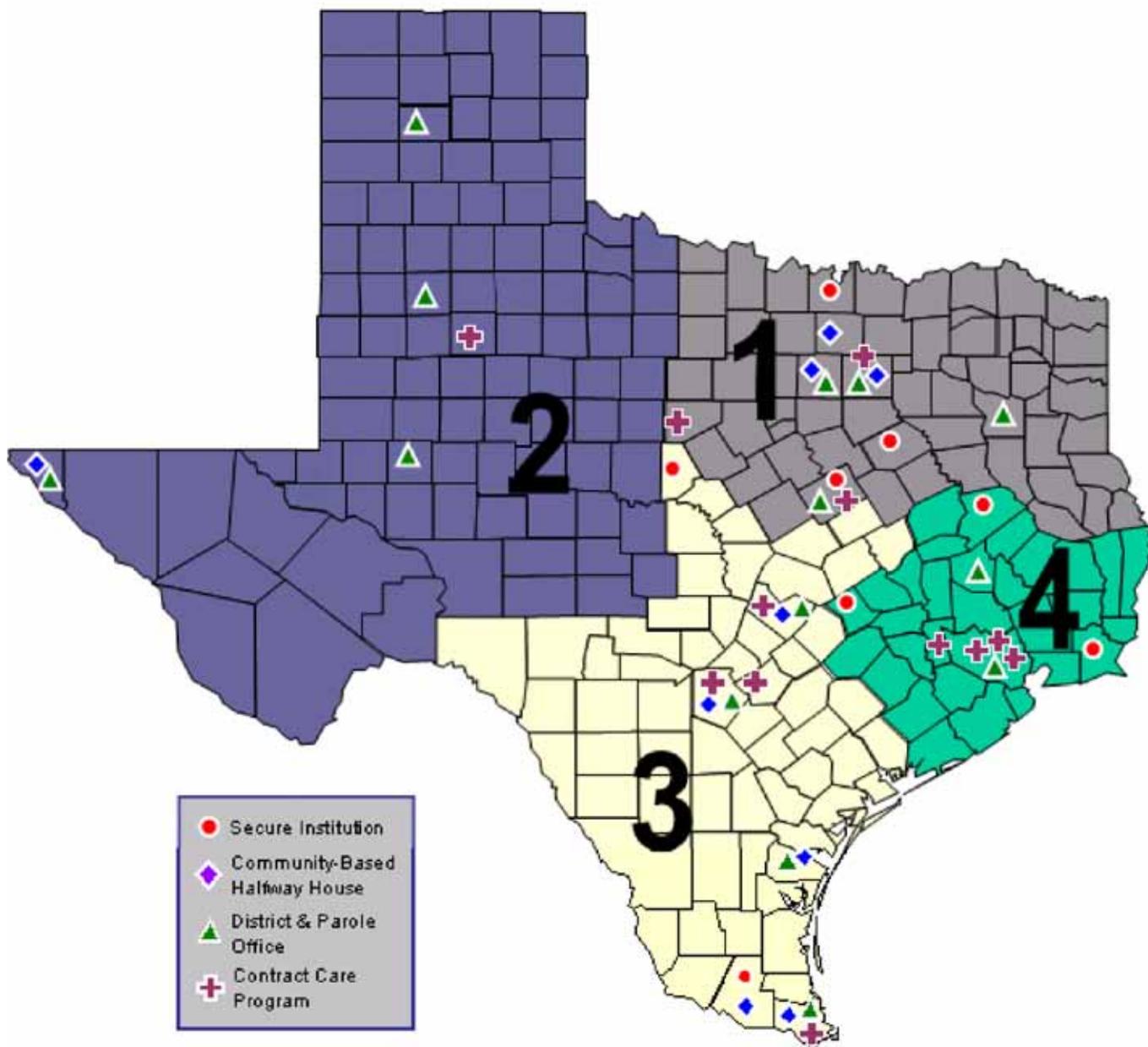


- [1 Edinburg](#)
- [2 Corpus Christi](#)
- [3 Victoria](#)
- [4 Houston](#)
- [5 Beaumont](#)
- [6 Huntsville](#)
- [7 Kilgore](#)
- [8 Mt. Pleasant](#)
- [9 Wichita Falls](#)
- [10 Richardson](#)
- [11 Fort Worth](#)
- [12 Waco](#)
- [13 Austin](#)
- [14 Abilene](#)
- [15 San Angelo](#)
- [16 Amarillo](#)
- [17 Lubbock](#)
- [18 Midland](#)
- [19 El Paso](#)
- [20 San Antonio](#)

TEXAS JUVENILE PROBATION COMMISSION REGIONS

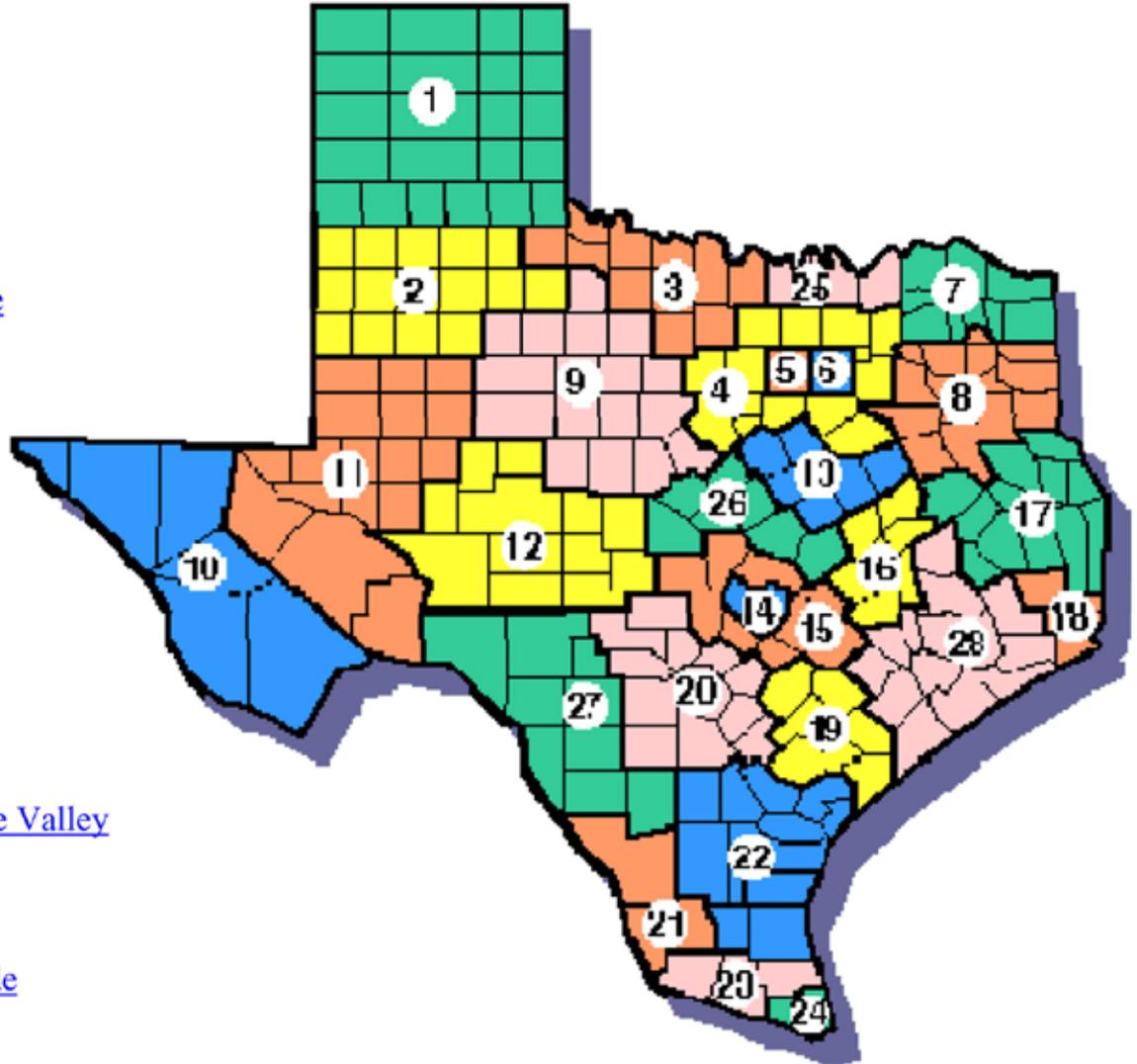


TEXAS YOUTH COMMISSION DISTRICTS

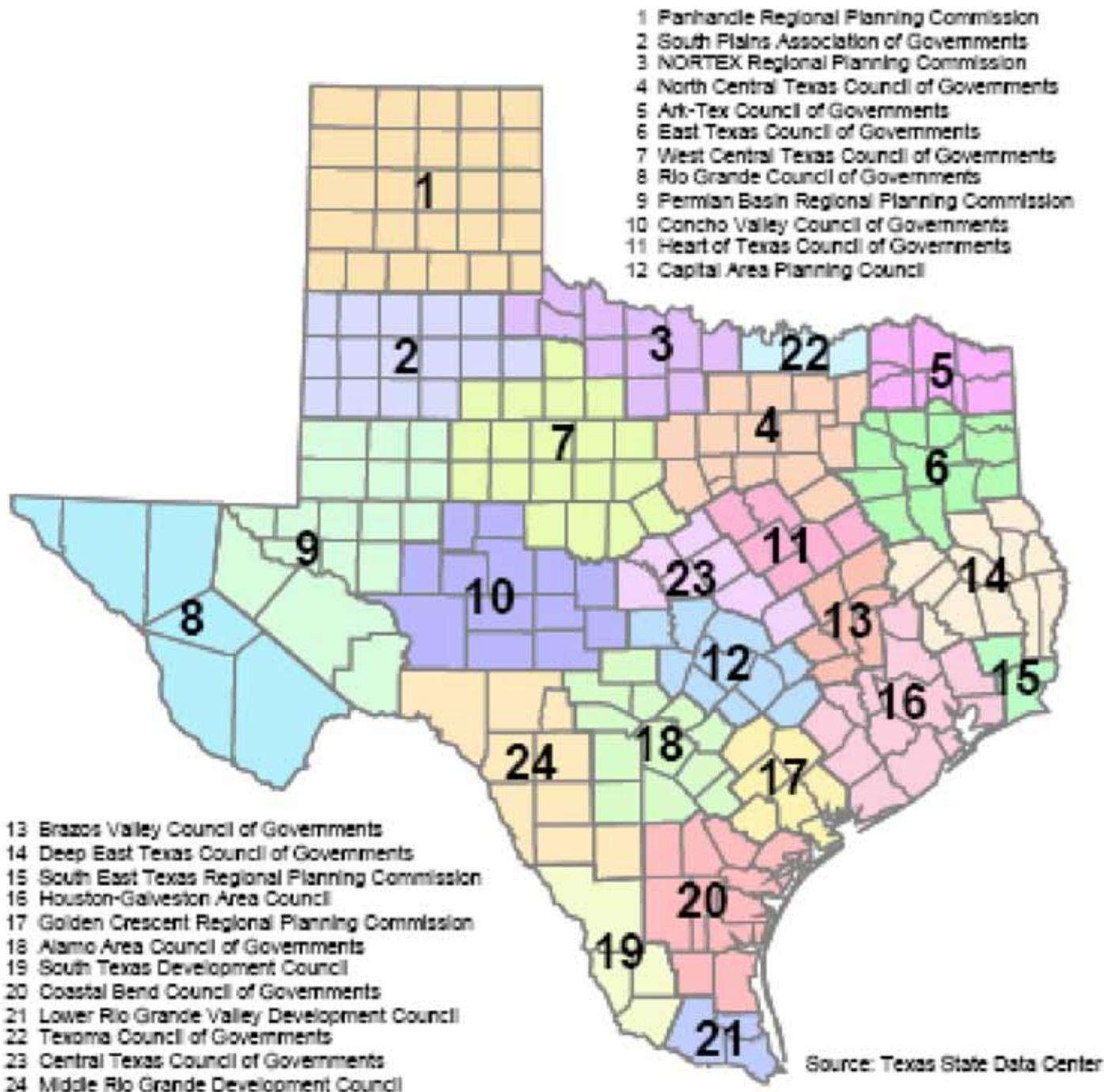


LOCAL WORKFORCE DEVELOPMENT BOARDS

- . [Panhandle](#)
- . [South Plains](#)
- . [North Texas](#)
- . [North Central](#)
- . [Tarrant County](#)
- . [Dallas](#)
- . [North East](#)
- . [East Texas](#)
- . [West Central](#)
- 0. [Upper Rio Grande](#)
- 1. [Permian Basin](#)
- 2. [Concho Valley](#)
- 3. [Heart of Texas](#)
- 4. [Capital Area](#)
- 5. [Rural Capital](#)
- 6. [Brazos Valley](#)
- 7. [Deep East Texas](#)
- 8. [South East Texas](#)
- 9. [Golden Crescent](#)
- 0. [Alamo](#)
- 1. [South Texas](#)
- 2. [Coastal Bend](#)
- 3. [Lower Rio Grande Valley](#)
- 4. [Cameron County](#)
- 5. [Texoma](#)
- 6. [Central Texas](#)
- 7. [Middle Rio Grande](#)
- 8. [Gulf Coast](#)



TEXAS COUNCILS OF GOVERNMENTS



Purpose for a System of Regional Leadership Councils on Children and Families

1. Improve coordination among local health and human services, education, juvenile justice, and workforce systems, to ensure that children and families have access to needed services;
2. Improve coordination and efficiency among local and regional governments, local agencies, and service providers on issues affecting children;
3. Prioritize and mobilize resources for children;
4. Facilitate an integrated approach to providing services for children and youth at the local and regional level;
5. Increase local control, ownership and commitment to children, youth and their families;
6. Increase community voice, including family engagement and involvement, in the development of policies, programs, services and supports;
7. Improve the health, safety, social-emotional development, and learning outcomes in communities;
8. Improve prevention, early identification and early intervention to reduce the long-term stress on health and human services, education, juvenile justice, and workforce systems;
9. Promote school readiness; and
10. Promote youth who successfully transition to adulthood into the workforce or higher education.

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Texas Title V FY11 Activity Plan – NPM01

National Performance Measure 01: *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.*

FY 11 Activities

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.

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

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

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

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

Monitoring: Document distribution of materials and interactions with stakeholders.

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

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

Monitoring: Ensure 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 and post-analytical stages of the newborn screening process.

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

Monitoring: Track progress at regularly scheduled steering committee meetings.

Title V FY11 Activity Plan – NPM02

National Performance Measure 02: *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.*

FY 11 Activities

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 active CYSHCN/ family electronic mail distribution lists and key stakeholder groups with significant CYSHCN/ family membership (including contractor advisory groups); documentation of staff and contractor participation in stakeholder groups with significant CYSHCN/family membership; identification of key family input and impact on program activity planning (Annual Title V CYSHCN Activity Plan); documentation of training and other efforts to promote family involvement and partnership in decision-making at state, local, and individual levels.

Monitoring: Information from electronic mail distribution lists, Stakeholder Meeting Records and regional meeting/events data, contractor quarterly reports of priority concerns/suggestions relevant to CYSHCN and their families; program discussions and use of family inputs in decision-making and activity planning, staff reporting of training and other efforts.

Activity 2: Monitor consumer satisfaction with CSHCN Services Program (SP) contractor services.

Output Measure(s): Indicators of level of satisfaction with CSHCN SP contractor services such as contractor quarterly satisfaction survey results and the percentage of their clients who are satisfied with core topic areas as well as other services they receive through the contractor and "Priority concerns/suggestions relevant to CYSHCN" from the contractor Stakeholder Meeting section of quarterly report; recommendations/input to contractors from consumers; and contractor response to consumer feedback.

Monitoring: Review contractor quarterly reports.

Activity 3: Assess consumer needs and satisfaction pertaining to health care benefits and state service systems.

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

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

Title V FY11 Activity Plan – NPM 03

National Performance Measure 03: *Percent of Children with Special Health Care Needs age 0-18 who receives coordinated, ongoing, comprehensive care within a medical home.*

FY 11 Activities

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

Output Measure(s): Progress on MHWG strategic plan, MHWG minutes, and 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 Provider Bulletin and Family Newsletter; presentation schedule (conferences, seminars, and other venues); website postings to primary websites - CSHCN SP website and Texas page of AAP medical home website, and other relevant websites; development and dissemination of materials/tools information.

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

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

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

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

Activity 3: Collaborate with the Medicaid Health Home Project and other initiatives to increase CYSHCN access to quality medical homes and integrated dental and mental/behavioral health services.

Output Measure(s): Documentation of the implementation and progress of the Texas Medicaid Health Home Project; documentation of the implementation and progress of other Medical Home initiatives, identifying any specific emphasis on integration of dental and mental health services; implementation of the transition component of the Texas Patient-Centered Medical Home Demonstration Project (Texas Medical Home Initiative).

Monitoring: Review of Medicaid Health Home Project and other initiative activity and data reports.

Title V FY11 Activity Plan – NPM 04

National Performance Measure 04: *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.*

FY 11 Activities

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

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

Monitoring: Documentation of progress made on collaborative efforts; ongoing identification of Federal Health Care Reform developments and assessment of impact for CYSHCN.

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

Output Measure(s): Number of CSHCN SP health care benefits clients by age (i.e. ongoing clients, received CSHCN SP health care benefits, on the waiting list, on the waiting list with no other source of insurance, removed from the waiting list); number of CSHCN SP health care benefits clients who received Insurance Premium Payment Assistance (IPPA); number of CSHCN SP clients/families provided home modifications through the CSHCN SP family support services (FSS); number of CSHCN SP clients/families provided van modifications through the CSHCN SP FSS; documentation of efforts to increase number of CSHCN SP providers and outcomes of those efforts.

Monitoring: Review monthly CSHCN SP health care benefits client and provider data (from Texas Medicaid Health Care Partnership (TMHP) and program quarterly data summary reports).

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

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

Monitoring: Review contractor quarterly reports; program articles published; and other means of communication.

Title V FY11 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.*

FY 11 Activities

Activity 1: Collaborate with Texas Information and Referral/2-1-1 system to foster and improve effective awareness and linkage to community services and supports for CYSHCN and their families.

Output Measure(s): 2-1-1 Texas 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.

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

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.

Output Measure(s): Groups in which CSHCN SP staff and contractors actively participate; review of Stakeholder Meeting Records to identify key issues, needs, and recommendations and inform Title V activity planning; completion of the DSHS Case Management training module by CSHCN SP staff, contractors, and others.

Monitoring: Review Stakeholder Meeting Records, contractor quarterly reports, annual Title V Activity Plan; DSHS training module data.

Activity 3: Enhance and promote the use of “People-First” language and use of appropriate languages, literacy levels, and cultural approaches in all communications regarding CYSHCN and their families.

Output Measure(s): Use of and efforts to promote use of “People First” language and appropriate literacy levels in publications, website content and in interactions with stakeholders; bilingual publications and Spanish language content; completion of the DSHS Cultural Competency training module by CSHCN SP staff, contractors, and others.

Monitoring: Review media, staff activities, DSHS training module completion data, contractor technical assistance, site observations, communications, and quarterly reports.

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

Output Measure(s): Number of CYSHCN receiving case management, family supports and community resources from the CSHCN SP contractors, regional staff, and health care benefits

Monitoring: Review contractor and regional quarterly activity reports and CSHCN SP health care benefits family support services data.

Title V FY11 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.*

FY 11 Activities

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

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

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

Title V FY11 Activity Plan – NPM 06

National Performance Measure 06: *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.*

FY 11 Activities

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

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

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

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

Output Measure(s): Youth, adult, and family advisors identified and input/guidance received on transition activities; survey of adults who were former CSHCN SP clients.

Monitoring: Review progress and results reports.

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

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

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

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

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

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

Title V FY11 Activity Plan – NPM 07

National Performance Measure 07: *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.*

FY 11 Activities

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

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

Monitoring: Track the number and type of partnership activities.

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

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

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

Title V FY11 Activity Plan – NPM 08

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

FY 11 Activities

Activity 1: Increase opportunities to engage in teen pregnancy prevention activities at the state and local levels.

Output Measure(s): Number of procurement opportunities for teen pregnancy prevention service provision; number of Title V, X, and XX contractors; the number of teens (age 17 and under) receiving family planning services.

Monitoring: Review contractor quarterly and annual reports for number of clients served.

Activity 2: 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 National Stakeholders Collaborative and YRBS fact sheets.

Monitoring: Copy of materials or products distributed; summary of annual events.

Activity 3: Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent adolescent pregnancy.

Output Measure(s): Number of meetings and types of partners engaged; developed proposals for implementation; implemented activities; number of Power2Wait toolkits distributed; number of Youth Leadership Clubs.

Monitoring: Review meeting notes; quarterly progress reports.

Activity 4: Coordinate and implement regional and local teen pregnancy prevention activities.

Output Measure(s): Number and type of activities coordinated by or implemented by Health Service Region Staff; number of teen pregnancy prevention activities provided through the Education Service Centers.

Monitoring: Review quarterly progress reports.

Activity 5: Implement Texas Healthy Adolescent Initiative in local communities.

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

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

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

FY 11 Activities

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

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

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

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

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

Monitoring: Analyze, interpret, and report on data collected

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

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

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

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

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

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

Title V FY11 Activity Plan – NPM 10

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

FY 11 Activities

Activity 1: Distribute child safety seats to low-income families via educational classes throughout the state.

Output Measure(s): Number of organizations that participate in the distribution and education program; the number of safety seats issued to participating organizations; and the number of safety seats distributed.

Monitoring: Maintain a current list of participating organizations; track the number of seats distributed to the organizations on an ongoing basis.

Activity 2: Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.

Output Measure(s): Number of CPS technician training courses per quarter; number of students per course; number of update/renewal classes for certified CPS technicians; number of students per update/renewal classes.

Monitoring: Track number of technician training courses (per calendar year); number of students per course; number of update/renewal classes per year; number of students per class.

Activity 3: Conduct traffic safety presentations throughout the state.

Output Measure(s): Number of traffic safety presentations conducted; number of persons attending each presentation.

Monitoring: Track progress of presentations conducted (per calendar year).

Activity 4: Review of report on child deaths resulting from motor vehicle crashes and develop policy recommendations and activities aimed at reducing such deaths.

Output Measure(s): Annual Child Fatality Review Team Report on child deaths that includes motor vehicle crash deaths and policy recommendations; CFRT involvement in motor vehicle safety awareness activities; training session(s) on reducing motor vehicle crash deaths and appropriate prevention strategies at CFRT Annual Conference.

Monitoring: Updates on child deaths, prevention and training activities, and potential recommendations at quarterly State Child Fatality Review Team Committee meetings.

Activity 5: Conduct regional motor vehicle safety activities throughout the public health regions.

Output Measure(s): 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: Quarterly progress reports.

Title V FY11 Activity Plan – NPM 11

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

FY 11 Activities

Activity 1: Develop promotion and support of breastfeeding in the community.

Output Measure(s): Completed community support report including indicators related to breastfeeding rates; information, communication, referrals, and outreach activities; mother-to-mother support; professional support; and infrastructure building activities.

Monitoring: Review progress toward completion of report.

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

Output Measure(s): Completed health services report including indicators related to birth facility support and information, education, and communication for health services.

Monitoring: Review progress toward completion of report.

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

Output Measure(s): Completed workplace report including indicators related to increasing support for breastfeeding in the workplace through population based activities and infrastructure building activities.

Monitoring: Review progress toward completion of report.

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

Output Measure(s): Number and types of activities implemented within DSHS from the DSHS Infant Feeding Strategic Plan.

Monitoring: Document progress toward implementation of strategic plan.

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

FY 11 Activities

Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria.

Output Measure(s): Number of compliant and noncompliant programs that report newborn hearing data to DSHS.

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

Activity 2: Evaluation of the TEHDI program utilizing system data to manage the program.

Output Measure(s): Number and percent of infants screened before 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: Collaborate with multiple stakeholders to develop and disseminate educational materials for providers and parents.

Output Measure(s): Number and type of stakeholders involved in activities, type and number of materials developed and disseminated, number of stakeholder meetings held.

Monitoring: Documentation of meetings held and number of educational materials distributed; Review THSteps CE module completion records.

Activity 4: Provide training, outreach, and technical assistance to hospitals and medical home 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.

Title V FY11 Activity Plan – NPM 13

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

FY 11 Activities

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 Service Region reports.

Title V FY11 Activity Plan – NPM 14

National 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.*

FY 11 Activities

Activity 1: Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.

Output Measure(s): Number of WIC participants receiving nutrition education at time of benefit issuance. Type and number of activities included. Funding of WIC obesity projects. Funding registered dietitians at clinics to engage children at risk for obesity. Number of new mothers who choose to breastfeed.

Monitoring: Review quarterly WIC performance measure data on nutrition education contacts.

Activity 2: Study food consumption patterns in WIC families.

Output Measure(s): Number of surveys and studies conducted to determine food consumption patterns. Reports and presentations of findings.

Monitoring: Track quarterly progress on studies and analyses.

Activity 3: Identify factors that affect the redemption rate for WIC participants and the length of time participants remain on the WIC program.

Output Measure(s): Type and number of activities included; summary report on factors identified.

Monitoring: Track progress on activities and review report.

National Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

FY 11 Activities

Activity 1: Implement tobacco cessation social marketing campaign targeting pregnant women and expectant fathers.

Output Measure(s): Total number of media spots; Report detailing campaign impact; number of PSA DVDs ordered by hospitals and clinics for display on close circuit TVS, number of calls to Quitline resulting from campaign, number of web hits to campaign microsite, other activities that promote tobacco cessation.

Monitoring: Track campaign progress and development of report; review quarterly Health Service Region reports.

Activity 2: Monitor smoking rates in the last three months of pregnancy among adults and teens by race and ethnicity.

Output Measure(s): Written review of data, data review communicated to external stakeholders including March of Dimes, Healthy Start, WIC and Title V fee-for-service and population-based providers; information on website, including referral resources for providers and clients.

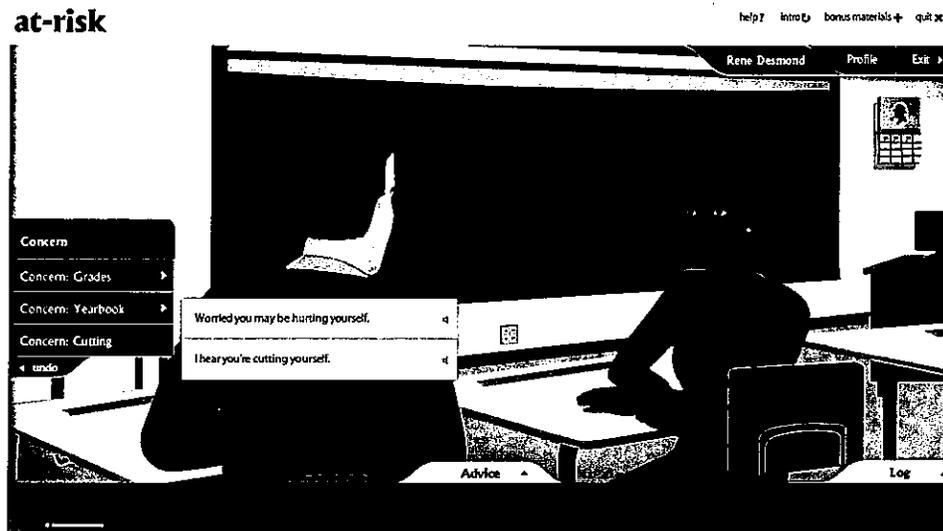
Monitoring: Review birth record, PRAMS, and Texas BRFSS data as available.

Activity 3: Develop and implement training for promotores/community health workers to provide smoking cessation interventions during pregnancy.

Output Measure(s): Training module developed and disseminated to approved organizations providing DSHS certified continuing education for promotores/community health workers; number of DSHS approved training programs adding the module to their approved curriculum; number of continuing education programs using the module held by DSHS approved training programs and number of participants trained.

Monitoring: Track development of module at regular work group meetings; track implementation of module through regular contact with the training programs and reports available on request.

Introducing *At-Risk Training* for Texas Public High School Educators



An interactive training simulation to build skills and confidence to identify and refer students in psychological distress

According to a CDC study, 14.5% of high school students had seriously considered suicide in the previous 12 months. Anxiety, depression, thoughts of suicide, and substance abuse are an unfortunate part of many high school students lives. Educators can play an important role in ensuring these students are referred and receive the professional help they need.

This unique, free, online course provides a virtual practice environment where teachers can engage in conversations with emotionally responsive student avatars so you are better prepared to handle similar situations in real-life. Educators will receive a Certificate of Completion for the one-hour course.

Texas Public High School Educators May Access the Online Course at:

www.MHATexas.org

If you have any questions, please contact: Mary Ellen Nudd, Mental Health America of Texas, menudd@MHATexas.org

**Thank you for helping create a safe and supportive environment
for yourself, your colleagues and Texas students.**

Title V FY11 Activity Plan – NPM 16

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

FY 11 Activities

Activity 1: Broaden the public's awareness of youth suicide, its risk factors, and prevention.

Output Measure(s): Establish website for suicide prevention information and resources; number of public awareness activities implemented through the Garrett Lee Smith Texas Youth Suicide Prevention (TYSP) Grant.

Monitoring: Document updates for the website regarding suicide information and prevention; document public awareness activities conducted as part of the TYSP grant.

Activity 2: Provide training to individuals, communities, and schools to identify and refer youth at higher risk of suicide and suicide attempts.

Output Measure(s): Number of individuals, communities and school personnel trained in QPR (Question, Persuade, Refer) and/or ASK (Ask about suicide, Seek more information, Know how and where to refer); Number of high school personnel trained in At-Risk (At-Risk is an interactive, web-based training simulation to teach school staff to effectively identify, approach and refer students At-Risk of suicide or suicide attempts).

Monitoring: Documentation of QPR, ASK, and At-Risk trainings completed.

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

Output Measure(s): Participate in the Texas Suicide Prevention Council; Obtain information about the Suicide Prevention Coalitions established statewide; number of regional activities.

Monitoring: Review meeting notes from the Texas Suicide Prevention Council; document suicide prevention activities implemented by the Council; track the contact information of the Suicide Prevention Coalitions; document local suicide prevention activities; review quarterly Health Service Region staff reports.

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

Output Measure(s): Public awareness/educational materials developed; suicide deaths of youth 17 and younger reported in the State Child Fatality Review Team Committee annual report; number of trainings on developing suicide prevention initiatives presented to CFRTs; and number of local initiatives developed by or participated in by CFRTs.

Monitoring: Track materials that are developed; provide updates of youth 17-and younger suicide deaths and local CFRT training and suicide prevention activities at quarterly State Committee meetings.

Title V FY11 Activity Plan – NPM 17

National Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

FY 11 Activities

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.

Output Measure(s): Number and type of contacts with internal and external partners regarding the standardization.

Monitoring: Document communication.

Activity 2: Define and map location of level III neonatal hospitals in Texas using hospital obstetric level self-designation status data, presence of a neonatal intensive care unit (NICU), number of NICU beds, and other criteria from the American Hospital Association (AHA) annual survey of hospitals.

Output Measure(s): Definition of a level III neonatal hospital in Texas; geocoded map of level III neonatal hospital locations.

Monitoring: Document communication.

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.

Title V FY11 Activity Plan – NPM 18

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

FY 11 Activities

Activity 1: Increase infrastructure for improving access to prenatal care.

Output Measure(s): Number and type of strategies to increase infrastructure for improving access to prenatal care, including regional activities; number of women receiving prenatal care through Title V contractors.

Monitoring: Document strategies.

Activity 2: Monitor percent of infants born to women who received early and adequate prenatal care through the analysis of previously collected surveillance data.

Output Measure(s): Percent of infants born to women who received early and adequate prenatal care.

Monitoring: Review birth record and PRAMS data.

Activity 3: Increase DSHS engagement in preconception and interconception health.

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

Monitoring: Document efforts with partners and document initiatives DSHS is involved with pertaining to preconception and interconception health.

State Performance Measure 01: *Change in percentage of CYSHCN living in congregate care settings as percent of base year 2003.*

FY 11 Activities

Activity 1: Provide and assess the provision of permanency planning services to families of CYSHCN who reside in or are at risk of placement in congregate care settings.

Output Measure(s): Number of CYSHCN assisted with permanency planning by CSHCN SP regional and contractor case management staff; information from HHSC Permanency Planning and Family-Based Alternatives Report (Senate Bill 368) such as 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 and placement in a family-based setting or placement in less restrictive environment other than a family-based setting, and trends in admission, discharge, placement; results of data analysis of permanency plans, as available.

Monitoring: Review quarterly regional activity reports, contractor quarterly reports, data from the HHSC Permanency Planning and Family-Based Alternatives Report (Senate Bill 368), and data analysis of permanency plans, as available.

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 services programs funded and promoted through CSHCN SP contracts; number of CYSHCN provided respite and other family support services (FSS) through CSHCN SP contractors and health care benefits; number of total respite hours provided by CSHCN SP contractors and health care benefits.

Monitoring: Review quarterly reports from the CSHCN SP health care benefits database and contractor quarterly reports.

Activity 3: Collaborate with public and private entities to support permanency planning and family-based living options 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 reports on relevant meetings attended by CSHCN SP staff, contractor quarterly reports, and reports of other activities.

FY 10 State Performance Measure Annual Report – SPM02

State Performance Measure 02: *The percent of obesity among women ages 18 to 44.*

Annual Objective & Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	23.0	22.5	22.0	26.5	26.0
Annual Indicator	24.5	27.3	27.0	26.8	28.5
Numerator	1,129,922	1,273,668	1,277,796	1,288,107	1,407,140
Denominator	4,613,620	4,666,871	4,732,576	4,806,369	4,937,333
Data Source			BRFSS	BRFSS	BRFSS
Provisional or Final?			Final	Final	Provisional
Notes	BRFSS is a sample survey; therefore, the numerator and denominator are not available. The annual indicator is the point estimate of the data collected after weighting. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by multiplying the percent from BRFSS and the total number of women 18 to 44 years of age. BRFSS data for 2010 are estimates. Estimates are linear projections based on data from 2005 through 2009.				

Activity 1: DSHS Central Office and Regional Office staff of the Nutrition, Physical Activity, and Obesity Prevention (NPAOP) Program will conduct trainings and provide technical assistance aimed at supporting community level (city/county) policy and environmental changes that address one or more of the 6 evidence-based obesity prevention strategies as defined by the Centers for Disease Control.

a. Last Year's Accomplishments

Contacts for FY10 included 2 trainings/workshops reaching 172 individuals and 187 technical assistance activities reaching organizations including schools and education-related organizations, public health organizations, advocacy groups, governmental organizations, health care organizations, community organizations, and business/industry. Topics included: improving nutrition through evidence-based worksite wellness activities; community collaboration related to nutrition and physical activity choices; weight maintenance/control; diabetes and nutrition; child nutrition/obesity; physical activity; farm direct/farm to work program development; decreased consumption of sugar sweetened beverages and high energy dense foods; increased consumption of fruits and vegetables; increased breastfeeding; childhood obesity prevention through improved nutrition practices in the day care setting; decreased screen time; and nutrition environment assessment. During this time period, trainings/workshops and technical assistance activities performed by the NPAOP Central and Regional Office staff led to 3 policy/environmental changes being implemented. First, Liberty Independent School District (ISD) and the Rotary Club implemented a Joint Use Agreement/policy so that the ISD will have use of Rotary Club land for a community garden at each school in the ISD. Second, the DSHS-funded Baby Café in San Antonio opened. This location will help meet the tenth step of the Baby Friendly Hospital Initiative and is an environmental change to support breastfeeding mothers. Third, a Farm to Work program was launched in San Antonio.

FY 10 State Performance Measure Annual Report – SPM02

State Performance Measure 02: *The percent of obesity among women ages 18 to 44.*

Activity 2: DSHS Central Office and Regional Office staff of the Nutrition, Physical Activity and Obesity Prevention (NPAOP) Program will contribute to the implementation of policy and environmental changes in a minimum of 6 communities (including one border community) that address one or more of the 6 evidence-based obesity prevention strategies as defined by the Centers for Disease Control.

a. Last Year's Accomplishments

DSHS Central Office and Regional staff were involved in activities related to policy and environmental change for 19 communities, 2 of which are communities along the Texas-Mexico border. All of the community projects use the Centers for Disease Control and Prevention (CDC) Recommended Strategies relating to 6 target areas: increase the consumption of fruits and vegetables; increase breastfeeding; decrease the consumption of sugar sweetened beverages; decrease the consumption of high energy dense foods; increase physical activity; and decrease television viewing. For these communities, there were 31 instances of technical assistance and 90 workshops/trainings that contributed towards policy and environmental change efforts. During FY10, 11 new policy/environmental changes were implemented. This includes a Farmers Market, 2 instances of increasing availability of healthier food and beverage choices in public venues, a policy to restrict less healthy foods in public venues, a policy to institute smaller portion sizes in public venues, a policy to limit advertisement for sugar sweetened beverages, a baby café launched to increase support to breastfeeding mothers, 2 instances of improving access to outdoor recreational facilities for increased physical activity, and a meeting space created for seminars to increase consumption of healthy foods. Of the 11 policy/environmental changes implemented, one was in a border community. This community improved access to outdoor recreational facilities by building a playscape.

Activity 3: Monitor obesity rates among women ages 18 to 44 years through the analysis of previously collected surveillance data.

a. Last Year's Accomplishments

The 2009 Texas Behavioral Risk Factor Surveillance System (BRFSS) data shows that 24.5% (20.8-28.7) of women ages 18 to 44 were obese. (135) According to PRAMS data, in 2009 25.5% (95% CI 22.6-28.4) of women ages 18-44 were overweight pre-pregnancy, and 25.5% (95% CI 22.6-28.5) of women ages 18-44 were obese pre-pregnancy. The BMI's from PRAMS are calculated from self-reported height and weight data.

Performance Assessment: The percentage of women 18-44 who are obese continued to increase slightly between 2008 and 2009. A focus on breastfeeding as primary prevention for obesity as well as future efforts targeting obese children may contribute to improvement in this measure.

State Performance Measure 02: *Rate of excess feto-infant mortality in Texas.*

FY 11 Activities

Activity 1: Identify excess feto-infant mortality using the Perinatal Periods of Risk (PPOR) map.

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

Monitoring: PPOR map.

Activity 2: Complete analyses to identify and prioritize factors with greatest contribution to feto-infant death disparities.

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

Monitoring: Document analyses and priorities.

Activity 3: Communicate findings of PPOR analyses to stakeholders.

Output Measure(s): Communications developed; communications disseminated; number and types of stakeholders; number and types of feedback received.

Monitoring: Document communication and feedback received.

Activity 4: Develop and disseminate materials and activities aimed at increasing awareness about infant health promotion and prevention of feto-infant mortality.

Output Measure(s): Public awareness, educational materials, and activities developed; dissemination methods identified; materials and information disseminated.

Monitoring: Document materials, activities, and dissemination methods; review quarterly Health Service Region reports.

FY 10 State Performance Measure Annual Report – SPM03

State Performance Measure 03: *Percent of licensed child care centers in metropolitan counties that have no deficiencies in operational policies that address health and safety of children.*

Annual Objective & Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	90.0	90.0	90.5	42.0	42.3
Annual Indicator		30.1	41.6	50.6	53.0
Numerator		2,806	3,772	4,684	4,916
Denominator	7,500	9,319	9,057	9,254	9,273
Data Source			Dept of Family & Protective Svcs	Dept of Family & Protective Svcs	Dept of Family & Protective Svcs
Provisional or Final?			Final	Final	Final
Notes					

Activity 1: Explore opportunities to target child care facilities with health and safety information.

a. Last Year's Accomplishments

Healthy Child Care Texas (HCCT) reported 32 encounters with child care and Head Start facilities (trainings and consultations) on health and safety topics including abuse and neglect, child development, use of community resources, cultural sensitivity, environmental health, infectious disease, injury prevention, mental health, nutrition, oral health, physical activity, playground safety, caring for children who are temporarily ill, caring for children with special needs, toilet training, health and safety of child care staff, and disaster preparedness. Some of these encounters also included classroom/program environmental assessments. In these encounters, 157 administrators and 302 staff were served, responsible for service to 4,721 children. The HCCT website experienced a malfunction in March 2010 and the data collection component was unable to be fixed. Therefore, only data through the month of March was collected – with some consultants faxing or emailing in their information. Therefore, an accurate count of children, parents, and child care providers served is not available. However, this function will be restored in the coming months with the launch of the new Healthy Child Care Texas website.

Activity 2: Ensure active participation on the Healthy Child Care Texas committee and related activities.

a. Last Year's Accomplishments

The HCCT Task Force met in March 2010 to discuss future plans for outreach and recruitment and to adjust the HCCT Action Plan, including creating a new mission statement. Title V MCH staff continued to participate on the task force.

Performance Assessment: There was an 8% increase in the percent of licensed child care centers in metropolitan counties that have no deficiencies in operational policies that address health and safety of children. Information and resources continue to be developed for distribution to child care centers in order to improve deficiency rates.

State Performance Measure 03: *The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.*

FY 11 Activities

Activity 1: Assess current level at which programs are working to enhance statewide capacity to address mental and behavioral health for MCH population.

Output Measure(s): Number of surveys distributed to MCH programs; number and type of MCH programs responding to survey; assess what has already been accomplished by the Mental Health Transformation work group efforts and other efforts around the agency.

Monitoring: Review of annual survey results.

Activity 2: Develop cross divisional opportunities for programs to increase capacity in addressing mental and behavioral health in MCH populations.

Output Measure(s): Number of cross divisional partnerships; number and type of activities implemented.

Monitoring: Summary of partnerships and activities.

Activity 3: Partner with internal and external partners to enhance and incorporate mental and behavioral health for MCH populations into their efforts.

Output Measure(s): Number of meetings and types of partners engaged; number and type of activities implemented.

Monitoring: Document meetings or plans developed with partners.

Activity 4: Increase opportunities to enhance and improve the quality of the data sources related to mental and behavioral health.

Output Measure(s): Number of data sources that collect information about mental and behavioral health.

Monitoring: Use of data in reports, grants, and other documents; review quarterly Health Service Region reports.

State Performance Measure 04: *The percent of women between the ages of 18 and 44 who are current cigarette smokers.*

FY 11 Activities

Activity 1: Provide smoking cessation training using the *Yes You Can* Clinical Toolkit to healthcare professionals using Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Center staff.

Output Measure(s): Number of trainings held; number of toolkits distributed; number of referrals to Quitline by healthcare professionals.

Monitoring: Quarterly total of training sessions held; materials distributed; and Quitline referrals made.

Activity 2: Distribute cessation and secondhand smoke educational materials through Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Centers.

Output Measure(s): Number and type of materials distributed.

Monitoring: Number of materials distributed and the number of hits to yesquit.org website.

Activity 3: Monitor smoking rates among women age 18-44 by race and ethnicity and by pregnancy status through the analysis of previously collected surveillance data.

Output Measure(s): Percent of women aged 18-44 who smoke by race and ethnicity, percent of women who smoked prior to pregnancy, percent of women who smoked during pregnancy, and percent of women who smoke in the postnatal period.

Monitoring: Review birth record, PRAMS, and Texas BRFSS data as available.

FY 10 State Performance Measure Annual Report – SPM05

State Performance Measure 05: *The prevalence of at-risk obesity and obesity among adolescents enrolled in high school.*

Annual Objective & Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	28.0	27.0	26.0	31.0	31.0
Annual Indicator	29.0	31.6	31.6	29.2	29.2
Numerator	363,380	403,049	409,893	380,582	387,722
Denominator	1,253,033	1,275,472	1,297,130	1,303,363	1,327,815
Data Source			YRBS	YRBS	YRBS
Provisional or Final?			Final		Provisional
Notes	<p>The Youth Risk Behavior Survey is conducted every other year in odd years. While point estimates are repeated in the even years, adjustments based on population change are reported. Denominator data are from Enrollment in Texas Public Schools report (Source: Texas Education Agency: http://www.tea.state.tx.us/index4.aspx?id=4128). Numerator data are calculated by multiplying the point estimate from the Youth Risk Behavior Survey and the enrollment data in the denominator.</p>				

Activity 1: Collaborate with the School Physical Activity Nutrition (SPAN) group to continue collecting data on demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th grade children and their parents, 8th graders and 11th graders.

a. Last Year's Accomplishments

During FY10, University of Texas School of Public Health (UTSPH) and the Michael and Susan Dell Center for Advancement of Healthy Living recruited 398 independent school districts (ISDs) for participation in the School Physical Activity Nutrition (SPAN) survey. Data collection began in January 2010, and over 15,000 students and parents were surveyed. Survey administration partners include: Gulf Coast Area Health Education Center, regional nutritionists working in the DSHS Health Service Regions (HSRs), Scott & White Healthcare, and staff from UTSPH Regional Campuses, including Austin. Data collection will continue into fall 2010 due to some schools unable to participate in spring 2010.

Activity 2: Identify and implement successful childhood obesity prevention efforts at the local level.

a. Last Year's Accomplishments

The Nutrition, Physical Activity and Obesity Prevention (NPAOP) program, Office of Title V and Family Health, and the Office of Border Health provided funding to communities to address policy and environmental change related to physical activity and nutrition. Five organizations are currently funded using Title V funds to address policy and environmental changes specific to children and adolescents. These communities include Dallas, San Marcos, Bryan, McAllen, and an organization that covers an additional 54 communities to address the needs of migrant workers. Activities that occurred during FY10 included coalition and partnership building with local organizations and businesses such as restaurants for promoting healthy children's menu options; conducting community needs assessments to identify local priorities and creating a curricula for youth-led involvement in the project through photovoice; conducting focus groups to gather information about making communities safe and walkable; meeting with school principals, school health advisory councils, school health services personnel and others to begin exploring options for creating physical activity infrastructure in the community; and educating Head Start teachers and administrators around the state on the "I Am Moving I Am Learning" curriculum to help reduce screen time in Head Start Programs and increase physical activity.

FY 10 State Performance Measure Annual Report – SPM05

State Performance Measure 05: *The prevalence of at-risk obesity and obesity among adolescents enrolled in high school.*

Activity 3: Disseminate information and resources about the prevalence and risk factors associated with adolescent obesity to school administrators, teachers, school nurses, parents and students.

a. Last Year's Accomplishments

3,858 professionals and 664 community members received information about nutrition, physical activity, and obesity prevention through awareness presentations and three-hour workshops provided by the school health specialists at regional education service centers. Thousands of other professionals received information through mass email communication and other electronic methods including the weekly DSHS Friday Beat electronic newsletter. Regional Title V staff continued to provide information through health fairs and to participate with School Health Advisory Committees (SHACs), community coalitions and workgroups related to diabetes, physical activity, recreation and exercise (including Walk Across Texas campaign planning), nutrition, breastfeeding, children's health, and community gardening. Staff worked with SHACs to identify schools without a school nurse and assist in distributing Get Fit Kits, described in detail under Activity 4 below. Over 5,000 children were served through selected regional activities.

Activity 4: Coordinate healthy living activities (i.e. healthy eating, physical activities) to target adolescents.

a. Last Year's Accomplishments

Get Fit Kits, a toolkit for school nurses to use with adolescents identified through Acanthosis Nigricans screening or FITNESSGRAM as overweight or obese, were distributed to school nurses, school health specialists, regional nutritionists and nurses, and health educators across the state. The Get Fit Kits were promoted at the Texas School Nurse Conference in Dallas in October 2009. There were 5,000 hard-copy toolkits that were printed and distributed in FY10. The website, www.getfitkit.org, includes all of the information available in the toolkit in a downloadable format and is accessible to the general public.

Performance Assessment: New data from the School Physical Activity and Nutrition (SPAN) study, 2009-2011, show that the rates of obesity in high school students significantly increased from 2004-2005, so that now more than 1 in 5 11th grade students in Texas are obese. Between the surveys, the health requirement for high school students was dropped, and physical education programs were cut by one semester. To affect the rates of adolescent obesity, activities must continue to address environmental and other confounding factors of obesity-related behaviors prior to adolescence.

State Performance Measure 05: *The percent of obesity among school-aged children (grade 3-12).*

FY 11 Activities

Activity 1: Collaborate with the School Physical Activity Nutrition (SPAN) workgroup to examine demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th grade children and their parents, 8th graders and 11th graders.

Output Measure(s): Prevalence of overweight and obesity among Texas school children by grade, gender and race/ethnicity; analysis to identify sociodemographic, social, and mental health correlates of obesity.

Monitoring: Monthly meetings to review study progress and outline dissemination activities.

Activity 2: Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent school-aged childhood obesity.

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

Monitoring: Quarterly review of implemented activities and overall progress.

Activity 3: Disseminate information and resources about the prevalence and risk factors associated with school-aged childhood obesity.

Output Measure(s): Number, type, and format of materials provided.

Monitoring: Quarterly review of information and resources distributed.

Activity 4: Coordinate and implement regional and local childhood obesity prevention activities.

Output Measure(s): Number and type of activities coordinated or implemented by Health Service Region Staff; number of childhood obesity prevention activities provided through the Education Service Centers.

Monitoring: Review quarterly Education Service Center progress reports; review quarterly Health Service Region reports.

FY 10 State Performance Measure Annual Report – SPM06

State Performance Measure 06: *The percent of Texas Health Steps eligible children provided dental services.*

Annual Objective & Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	42.0	42.5	43.0	43.5	44.0
Annual Indicator	40.0	42.1	41.6	44.3	51.6
Numerator	1,047,804	1,112,410	1,224,309	1,379,211	1,592,183
Denominator	2,532,422	2,620,912	2,642,556	2,943,128	3,111,775
Data Source			Form CMS-416	Form CMS-416	Form CMS-416
Provisional or Final?			Final	Final	Final
Notes	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.				

Activity 1: Provide preventive dental services to preschool and school-aged children across the state enrolled in the free and reduced lunch program.

a. Last Year's Accomplishments

During FY10, the DSHS Oral Health Program (OHP) regional dental teams provided preventive dental services to 11,789 preschool and school-aged children. Of the 11,789 children, 4,159 received dental sealants.

Activity 2: Continue to support collaborations to promote oral health prevention through water fluoridation and dental sealants.

a. Last Year's Accomplishments

For FY10, the DSHS OHP regional dental teams collaborated with approximately 200 public elementary schools and Head Start programs and 25 dental stakeholders including dental professional groups, dental and dental hygiene academic programs, and local health departments in rural and underserved areas of the state providing free preventive dental services to low-income children. These services included the provision of 18,419 dental sealants to 4,159 preschool and school-aged children.

Activity 3: Continue providing training to local water system operators, on-site inspections of system/equipment needs, and technical assistance to communities in need of fluoridation systems or upgrades.

a. Last Year's Accomplishments

In FY10, 36 site inspections were conducted at 29 public water systems and technical assistance was provided to all. Five trainings were held for 96 operators covering the benefits of fluoridation, chemical handling safety, testing, dosage calculations, and operation of fluoridation facilities. Equipment was purchased and installed at 2 of the systems. The Fluoridation pamphlet was updated and printed for public education.

FY 10 State Performance Measure Annual Report – SPM06

State Performance Measure 06: *The percent of Texas Health Steps eligible children provided dental services.*

Activity 4: Collaborate with multiple stakeholders to develop activities and materials to promote the dental home concept and early intervention to both providers and recipients of services.

a. Last Year's Accomplishments

DSHS OHP continues to provide training to pediatric and general dentists who provide dental homes for Medicaid children between 6-35 months of age. OHP has also worked with the Texas Dental Association's Council on Access to Dental Care in Medicaid and CHIP and the Texas Association of General Dentists to raise awareness about the dental home concept and the importance of early intervention to prevent and/or decrease the occurrence of dental decay.

Performance Assessment: There was an increase of 16.5% in 2010 of the number of Texas Health Steps eligible children provided preventative dental services. A small portion of this increase can be attributed to adjusting the base population to reflect only those who were eligible for 90 continuous days; therefore reducing the number of individuals in the base population by 10 percent. Texas continues to be above the annual performance objective. Increased training opportunities, intervention/prevention awareness, and collaborations with local schools and Head Start programs may have contributed to the increase in services provided.

State Performance Measure 06: Rate of preventable child deaths (0-17 year olds) in Texas.

FY 11 Activities

Activity 1: Expand Child Fatality Review (CFR) to cover more children in Texas to increase the understanding of risk and protective factors.

Output Measure(s): Numbers of inquiries about new teams; CFR presentations conducted; number of newly-formed teams that review fatalities; number and type of activities coordinated or implemented by Health Service Region Staff.

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

Activity 2: Develop and implement a plan to increase the number of preventable child deaths reviewed, to improve the quality of the CFR data collected and to analyze data for Annual Report for recommendations of prevention activity direction, and other methods of dissemination.

Output Measure(s): Form Data Quality Workgroup in State CFRT Committee; create Data Quality Plan; deliver trainings on data collection and quality; and use 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 quarterly.

Activity 3: Organize and facilitate internal and external stakeholders to address prevention of child drowning deaths.

Output Measure(s): Form Statewide Drowning Prevention Task Force to develop state plan to reduce drowning deaths.

Monitoring: Quarterly report from Task Force on progress.

Activity 4: Organize and facilitate internal and external stakeholders to address standardization of infant death scene investigations.

Output Measure(s): Establishment of Texas Sudden Unexpected Infant Death Investigation (SUIDI) Workgroup.

Monitoring: Quarterly reporting from Texas SUIDI Workgroup on progress.

FY 10 State Performance Measure Annual Report – SPM07

State Performance Measure 07: Rate of family violence incidents involving female victims per 1,000 women in Texas.

Annual Objective & Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	11.9	11.7	11.5	12.0	12.0
Annual Indicator	13.0	12.8	12.9	12.7	12.8
Numerator	152,549	151,092	156,055	156,958	158,685
Denominator	11,754,567	11,849,105	12,137,007	12,351,241	12,430,745
Data Source			TX Dept of Public Safety Crime Report	TX Dept of Public Safety Crime Report	TX Dept of Public Safety Crime Report
Provisional or Final?			Final	Final	Provisional
Notes					

Activity 1: Increase opportunities for family violence prevention activities at the state and local level.

a. Last Year's Accomplishments

In FY10, the Texas School Health Network (TSHN) served 1,793 people through awareness raising workshops. Topics included bullying prevention, internet safety and cyber-bullying, dating violence prevention, gangs and gang violence, best practices used to make schools safer, child abuse, and teens that self-injure. TSHN also provided ongoing communication on these topics to a large number of stakeholders through an email distribution list and Friday Beat newsletter.

Beginning in May 2010, Title V MCH staff began participating in the Texas Council on Family Violence's (TCFV) Project Connect Texas Leadership Team (TLT). The TLT offers guidance to TCFV on successfully implementing their efforts to integrate public health and violence prevention. In August 2010, Title V MCH staff met to discuss and develop a survey of providers to inform DSHS efforts to develop a best practice guide for providers working with survivors in abusive relationships. Project Connect agreed to take the best practice guide being developed by Title V MCH staff and to implement it as part of their grant.

Activity 2: Collaborate with the Office of the Attorney General on activities in conjunction with the Rape Prevention Education grant from the Centers for Disease Control and Prevention (CDC).

a. Last Year's Accomplishments

Title V MCH staff attended the October 2009 Primary Prevention and Planning Committee (PPPC) meeting. At this meeting, feedback from the Centers for Disease Control and Prevention (CDC) on the Texas State Plan for the Prevention of Sexual Assault was discussed, as well as next steps and plans for release and implementation. In November 2009, staff presented the State Plan with a panel of the PPPC at the Office of the Attorney General's 2009 Crime Victim Services Conference. In January 2010, the Final State Plan was submitted to CDC and distribution and planning for implementation began in February 2010. Title V MCH staff attended the PPPC meeting in March 2010, and assisted the group in implementation planning for the release of the State Plan. Response to a technical assistance report was completed and returned to CDC, carry forward fund requests were completed and granted for the Texas Peer Educators Acting for Change and Equality (PEACE) project, a continuation grant application was completed, and Title V MCH staff attended steering committee meetings to discuss local challenges in implementation of the State Plan.

FY 10 State Performance Measure Annual Report – SPM07

State Performance Measure 07: *Rate of family violence incidents involving female victims per 1,000 women in Texas.*

Activity 3: Integrate family violence prevention professionals into State Child Fatality Review Team and local Child Fatality Review Teams.

a. Last Year's Accomplishments

In February 2010, the State Child Fatality Review Team (SCFRT) prepared their recommendation for the Texas Legislature to include a family violence professional into the SCFRT. It will be considered in the 82nd Texas Legislative Session (2011). The State CFR Coordinator provided input on draft legislative language in preparation for the legislative session. Some local CFRT already have domestic violence advocates on their teams.

Activity 4: Participate on the Interpersonal Violence Prevention Collaborative steering committee.

a. Last Year's Accomplishments

The Interpersonal Violence Prevention Collaborative transitioned into a web-based, information-sharing group.

Performance Assessment: The rate of family violence incidents involving females increased slightly between 2008 and 2009. Efforts to increase health care response to domestic violence, partnership with organizations serving victims of both domestic and sexual violence, and collecting and analyzing data on this issue will continue to impact this measure into the future.

State Performance Measure 07: *The extent to which research findings and/or evidence-based practices are used to develop and improve DSHS programs serving MCH populations.*

FY 11 Activities

Activity 1: Assess current level at which programs are working to identify research findings and/or evidence-based practices for improving DSHS programs serving MCH populations.

Output Measure(s): Number of surveys distributed to DSHS programs; number and type of DSHS programs responding to survey; survey results indicating identification of research findings/evidence-based programs.

Monitoring: Review of annual survey results.

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

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

Monitoring: Documentation of materials/products distributed and activities completed.

Activity 3: Partner with external and internal stakeholders to identify opportunities to incorporate research findings/evidence-based practices.

Output Measure(s): Number of meetings and types of partners engaged; number and type of proposals developed for implementation; number and type of activities implemented.

Monitoring: Review meeting notes; copy of materials/plan developed.

FORM 2
MCH BUDGET DETAILS FOR FY2012

[Secs. 504(d) and 505(a)(3)(4)]

STATE: TX

1.	FEDERAL ALLOCATION		\$ <u>33,678,798.00</u>
	(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>10,103,639</u>	<u>30.00%</u>	
	Children with special health care needs:		
	\$ <u>10,103,639</u>	<u>30.00%</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>3,367,880</u>	<u>10.00%</u>	
	(The above figure cannot be more than 10% [Sec 504(d)])		
2.	UNOBLIGATED BALANCE	(Item 15b of SF 424)	\$ <u>9,306,829.00</u>
3.	TOTAL STATE FUNDS (MATCH & OVERMATCH)	(Item 15c of SF 424)	\$ <u>46,105,185.00</u>
	(Enter below your State's FY1989 Maintenance of Effort Amount)		
	A. \$ <u>40,208,728</u>		
4.	LOCAL MCH FUNDS	(Item 15d of SF 424)	\$ <u>0.00</u>
5.	OTHER FUNDS	(Item 15e of SF 424)	\$ <u>290,902.00</u>
6.	PROGRAM INCOME	(Item 15f of SF 424)	\$ <u>2,527,780.00</u>
7.	FEDERAL-STATE BLOCK GRANT PARTNERSHIP (SUBTOTAL)		\$ <u>91,909,494</u>
	(Total lines 1 through 6. Same as line 15g of SF424)		
8.	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>133,669</u>	
	c. CISS	\$ <u>NA</u>	
	d. Abstinence Education	\$ <u>NA</u>	
	e. Healthy Start	\$ <u>NA</u>	
	f. EMSC	\$ <u>NA</u>	
	g. WIC	\$ <u>598,926,315</u>	
	h. AIDS	\$ <u>0</u>	
	i. CDC	\$ <u>8,589,827</u>	
	j. Education	\$ <u>0</u>	
	k. Other: Family Planning (T-X)	\$ <u>17,680,526</u>	
	Other: NHSCPC/Male Involvement	\$ <u>701,336</u>	
9.	OTHER FEDERAL FUNDS (SUBTOTAL)		\$ <u>626,031,673</u>
10.	STATE MCH BUDGET GRAND TOTAL		\$ <u>717,941,167</u>
	(Partnership sub-total + Other Federal MCH Funds sub-total)		

Please note that Attachment V. A. includes the complete set of figures for 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.

FORM 3
STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506(a)(1-3)]

STATE: TX

	FY2007		FY2008		FY2009	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line 1, Form 2)</i>	\$ 35,207,084	\$ 29,112,519	\$ 34,184,513	\$ 23,645,937	\$ 34,437,266	\$ 22,940,016
2. Unobligated Balance <i>(Line 2, Form 2)</i>	\$ 9,453,858	\$ 9,453,858	\$ 6,094,565	\$ 6,094,565	\$ 10,538,576	\$ 10,538,576
3. State Funds <i>(Line 3, Form 2)</i>	\$ 49,894,116	\$ 42,279,557	\$ 49,477,783	\$ 46,530,321	\$ 51,524,933	\$ 47,579,451
4. Local Funding <i>(Line 4, Form 2)</i>	\$	\$	\$	\$	\$	\$
5. Other <i>(Line 5, Form 2)</i>	\$ 321,034	\$ 321,033	\$ 358,881	\$ 358,881	\$ 500,330	\$ 500,330
6. Program Income <i>(Line 6, Form 2)</i>	\$ 3,722,135	\$ 2,916,843	\$ 2,527,780	\$ 1,308,772	\$ 2,527,780	\$ 1,296,777
7. SUB-TOTALS <i>(Line 7, Form 2)</i>	\$ 98,598,227	\$ 84,083,810	\$ 92,643,522	\$ 77,938,476	\$ 99,528,885	\$ 82,855,150
8. Other Federal Funds <i>(Line 9, Form 2)</i>	\$ 536,132,177	\$ 513,581,744	\$ 599,153,044	\$ 592,755,986	\$ 650,771,604	\$ 593,470,866
9. TOTAL <i>(Line 10, Form 2)</i>	\$ 634,730,404	\$ 597,665,554	\$ 691,796,566	\$ 670,694,462	\$ 750,300,489	\$ 676,326,016

	FY2010		FY2011		FY2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line 1, Form 2)</i>	\$ 34,321,224	\$ 22,090,523	\$ 33,678,798	\$ 24,371,969	\$ 33,678,798	\$
2. Unobligated Balance <i>(Line 2, Form 2)</i>	\$ 11,497,250	\$ 11,497,250	\$ 12,230,701	\$ 12,230,701	\$ 9,306,829	\$
3. State Funds <i>(Line 3, Form 2)</i>	\$ 54,527,818	\$ 52,724,786	\$ 50,107,518	\$ 46,953,154	\$ 46,105,185	\$
4. Local Funding <i>(Line 4, Form 2)</i>	\$	\$	\$	\$	\$	\$
5. Other <i>(Line 5, Form 2)</i>	\$ 2,724,464	\$ 2,724,464	\$ 630,136	\$ 0	\$ 290,902	\$
6. Program Income <i>(Line 6, Form 2)</i>	\$ 2,662,461	\$ 2,662,461	\$ 2,527,780	\$ 1,170,725	\$ 2,527,780	\$
7. SUB-TOTALS <i>(Line 7, Form 2)</i>	\$ 105,733,217	\$ 91,699,484	\$ 99,174,933	\$ 84,726,549	\$ 91,909,494	\$ 0
8. Other Federal Funds <i>(Line 9, Form 2)</i>	\$ 614,570,436	\$ 554,949,188	\$ 626,097,672	\$ 289,703,292	\$ 626,031,673	\$ 0
9. TOTAL <i>(Line 10, Form 2)</i>	\$ 720,303,653	\$ 646,648,672	\$ 725,272,605	\$ 374,429,841	\$ 717,941,167	\$ 0

Please note that Attachment V. A. includes the complete set of figures for 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.

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

	FY 2007		FY 2008		FY 2009	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	\$ 16,611,700	\$ 14,166,331	\$ 8,876,337	\$ 7,467,421	\$ 7,512,182	\$ 6,253,691
b. Infants < 1 year old	\$ 162,351	\$ 138,452	\$ 82,667	\$ 69,545	\$ 83,829	\$ 69,785
c. Children 1 to 22 years old	\$ 23,668,159	\$ 20,184,024	\$ 18,085,599	\$ 15,214,923	\$ 22,402,238	\$ 18,649,268
d. CSHCN	\$ 43,904,493	\$ 37,441,414	\$ 47,303,013	\$ 39,794,738	\$ 50,933,788	\$ 42,401,024
e. All Others	\$ 7,912,268	\$ 6,747,521	\$ 11,707,672	\$ 9,849,346	\$ 11,455,934	\$ 9,536,761
f. Administration	\$ 6,339,256	\$ 5,406,069	\$ 6,588,235	\$ 5,542,503	\$ 7,140,916	\$ 5,944,622
g. SUB-TOTAL	\$ 98,598,227	\$ 84,083,811	\$ 92,643,522	\$ 77,938,476	\$ 99,528,885	\$ 82,855,150
II.						
a. SPRANS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
b. SSDI	\$ 94,570	\$ 47,687	\$ 94,644	\$ 41,141	\$ 93,390	\$ 45,928
c. CISS	\$ NA					
d. Abstinence Education	\$ NA					
e. Healthy Start	\$ NA					
f. EMSC	\$ NA					
g. WIC	\$ 511,964,687	\$ 489,627,661	\$ 575,269,987	\$ 570,388,826	\$ 626,194,623	\$ 570,259,737
h. AIDS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
i. CDC	\$ 7,155,348	\$ 7,049,242	\$ 7,669,273	\$ 6,638,745	\$ 8,265,037	\$ 7,943,474
j. Education	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
k. Other: Family Planning (T-X)	\$ 16,365,607	\$ 16,322,125	\$ 15,196,553	\$ 14,813,337	\$ 15,492,230	\$ 14,535,005
Other: NHSCPC	\$ 551,965	\$ 535,029	\$ 922,587	\$ 873,937	\$ 726,324	\$ 686,722
III. SUB-TOTAL	\$ 536,132,177	\$ 513,581,744	\$ 599,153,044	\$ 592,755,986	\$ 650,771,604	\$ 593,470,866
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	\$ 4,884,972	\$ 4,236,601	\$ 3,756,696	\$ 3,209,398	\$ 3,481,485	\$
b. Infants < 1 year old	\$ 49,240	\$ 42,704	\$ 58,558	\$ 50,027	\$ 54,268	\$
c. Children 1 to 22 years old	\$ 22,091,720	\$ 19,159,536	\$ 21,668,898	\$ 18,512,047	\$ 20,081,460	\$
d. CSHCN	\$ 56,138,783	\$ 48,687,608	\$ 48,377,638	\$ 41,329,701	\$ 44,833,549	\$
e. All Others	\$ 15,582,262	\$ 13,514,063	\$ 18,706,903	\$ 15,981,572	\$ 17,336,457	\$
f. Administration	\$ 6,986,240	\$ 6,058,972	\$ 6,606,240	\$ 5,643,804	\$ 6,122,274	\$
g. SUB-TOTAL	\$ 105,733,217	\$ 91,699,483	\$ 99,174,933	\$ 84,726,549	\$ 91,909,494	\$ 0
II.						
a. SPRANS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
b. SSDI	\$ 146,770	\$ 110,361	\$ 133,669	\$ 69,698	\$ 133,669	\$
c. CISS	\$ NA	\$				
d. Abstinence Education	\$ NA	\$				
e. Healthy Start	\$ NA	\$				
f. EMSC	\$ NA	\$				
g. WIC	\$ 589,027,739	\$ 531,716,251	\$ 598,926,315	\$ 265,119,427	\$ 598,926,315	\$
h. AIDS	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
i. CDC	\$ 8,700,753	\$ 8,042,946	\$ 8,655,826	\$ 8,404,238	\$ 8,589,827	\$
j. Education	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$
k. Other: Family Planning (T-X)	\$ 15,976,467	\$ 14,529,849	\$ 17,680,526	\$ 15,780,507	\$ 17,680,526	\$
Other: NHSCPC	\$ 718,707	\$ 549,781	\$ 701,336	\$ 329,422	\$ 701,336	\$
III. SUB-TOTAL	\$ 614,570,436	\$ 554,949,188	\$ 626,097,672	\$ 289,703,292	\$ 626,031,673	\$ 0

Please note that Attachment V. A. includes the complete set of figures for 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.

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICE

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: TX

	FY 2007		FY 2008		FY 2009	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN)	\$ 66,654,613	\$ 56,842,542	\$ 70,391,652	\$ 59,218,583	\$ 71,978,395	\$ 59,920,100
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)	\$ 8,091,316	\$ 6,900,212	\$ 5,719,376	\$ 4,811,556	\$ 5,899,031	\$ 4,910,786
III. Population Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education)	\$ 12,835,709	\$ 10,946,194	\$ 10,814,722	\$ 9,098,132	\$ 13,496,724	\$ 11,235,664
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)	\$ 11,016,590	\$ 9,394,863	\$ 5,717,772	\$ 4,810,206	\$ 8,154,735	\$ 6,788,601
V. Total Federal-State Partnership Budget & Expenditures	\$ 98,598,227	\$ 84,083,810	\$ 92,643,522	\$ 77,938,476	\$ 99,528,885	\$ 82,855,150

(Federal-State Partnership only. Item 15g of the SF424. For the "Budgeted" columns this is the same figure that appears in Line 7, 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 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN)	\$ 79,027,529	\$ 68,538,383	\$ 75,414,871	\$ 64,427,992	\$ 68,695,349	\$ 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)	\$ 5,817,801	\$ 5,045,617	\$ 5,170,657	\$ 4,417,366	\$ 5,057,173	\$ 0
III. Population Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education)	\$ 10,517,570	\$ 9,121,596	\$ 8,504,385	\$ 7,265,416	\$ 9,142,487	\$ 0
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)	\$ 10,370,316	\$ 8,993,887	\$ 10,085,020	\$ 8,615,775	\$ 9,014,485	\$ 0
V. Total Federal-State Partnership Budget & Expenditures	\$ 105,733,217	\$ 91,699,484	\$ 99,174,933	\$ 84,726,549	\$ 91,909,494	\$ 0

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

Please note that Attachment V. A. includes the complete set of figures for 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.

Texas FY12 Title V Block Grant Application Acronyms

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.
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.
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.

Texas FY12 Title V Block Grant Application Acronyms

Acronym	Name
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.
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.
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.
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.

Texas FY12 Title V Block Grant Application Acronyms

Acronym	Name
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.
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.
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.
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.
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.
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).

Texas FY12 Title V Block Grant Application Acronyms

Acronym	Name
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.
TEA	Texas Education Agency --State agency that provides leadership, guidance, and resources to help Texas schools meet the educational needs of all students.
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: 2012

- [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 2011](#)
- [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 2012

[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:

\$ 33,678,798

A.Preventive and primary care for children:

\$ 10,103,639 (30%)

B.Children with special health care needs:

\$ 10,103,639 (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:

\$ 3,367,879 (10%)

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

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

\$ 9,306,829

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

\$ 46,105,185

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

\$ 0

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

\$ 290,902

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

\$ 2,527,780

7. TOTAL STATE MATCH (Lines 3 through 6)

(Below is your State's FY 1989 Maintenance of Effort Amount)

\$ 40,208,728

\$ 48,923,867

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL)

(Total lines 1 through 6. Same as line 15g of SF 424)

\$ 91,909,494

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: \$ 133,669

c. CISS: \$ 0

d. Abstinence Education: \$ 0

e. Healthy Start: \$ 0

f. EMSC: \$ 0

g. WIC: \$ 598,926,315

h. AIDS: \$ 0

i. CDC: \$ 8,589,827

j. Education: \$ 0

k. Other: \$ 0

Family Planning X \$ 17,680,526

NHSCPC/Male Involvem \$ 701,336

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9)

\$ 626,031,673

11. STATE MCH BUDGET TOTAL

(Partnership subtotal + Other Federal MCH Funds subtotal)

\$ 717,941,167

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 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 LEVEL NOTES

None

FORM 3
STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506(a)(1-3)]

STATE: TX

	FY 2007		FY 2008		FY 2009	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation <i>(Line1, Form 2)</i>	\$ 35,197,324	\$ 29,112,519	\$ 35,207,084	\$ 23,645,937	\$ 34,184,513	\$ 22,940,016
2. Unobligated Balance <i>(Line2, Form 2)</i>	\$ 10,554,832	\$ 9,453,858	\$ 5,170,187	\$ 6,094,565	\$ 6,141,299	\$ 10,538,576
3. State Funds <i>(Line3, Form 2)</i>	\$ 49,894,116	\$ 42,279,557	\$ 46,447,844	\$ 46,530,321	\$ 46,447,844	\$ 47,579,451
4. Local MCH Funds <i>(Line4, Form 2)</i>	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
5. Other Funds <i>(Line5, Form 2)</i>	\$ 242,106	\$ 321,033	\$ 250,000	\$ 358,881	\$ 250,000	\$ 500,330
6. Program Income <i>(Line6, Form 2)</i>	\$ 3,722,135	\$ 2,916,843	\$ 2,527,780	\$ 1,308,772	\$ 2,527,780	\$ 1,296,777
7. Subtotal	\$ 99,610,513	\$ 84,083,810	\$ 89,602,895	\$ 77,938,476	\$ 89,551,436	\$ 82,855,150
(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)						
8. Other Federal Funds <i>(Line10, Form 2)</i>	\$ 511,985,836	\$ 513,201,034	\$ 532,544,302	\$ 592,634,344	\$ 575,780,008	\$ 593,470,866
9. Total <i>(Line11, Form 2)</i>	\$ 611,596,349	\$ 597,284,844	\$ 622,147,197	\$ 670,572,820	\$ 665,331,444	\$ 676,326,016
(STATE MCH BUDGET TOTAL)						

FORM 3
STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506(a)(1-3)]

STATE: TX

	FY 2010		FY 2011		FY 2012	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
1. Federal Allocation <i>(Line1, Form 2)</i>	\$ 34,446,314	\$ 22,090,523	\$ 34,437,266	\$	\$ 33,678,798	\$
2. Unobligated Balance <i>(Line2, Form 2)</i>	\$ 12,894,495	\$ 11,497,250	\$ 8,580,980	\$	\$ 9,306,829	\$
3. State Funds <i>(Line3, Form 2)</i>	\$ 56,129,051	\$ 52,724,786	\$ 54,886,980	\$	\$ 46,105,185	\$
4. Local MCH Funds <i>(Line4, Form 2)</i>	\$ 0	\$ 0	\$ 0	\$	\$ 0	\$
5. Other Funds <i>(Line5, Form 2)</i>	\$ 250,000	\$ 2,724,464	\$ 250,000	\$	\$ 290,902	\$
6. Program Income <i>(Line6, Form 2)</i>	\$ 37,706	\$ 2,662,461	\$ 2,527,780	\$	\$ 2,527,780	\$
7. Subtotal	\$ 103,757,566	\$ 91,699,484	\$ 100,683,006	\$ 0	\$ 91,909,494	\$ 0
(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)						
8. Other Federal Funds <i>(Line10, Form 2)</i>	\$ 570,310,569	\$ 554,949,188	\$ 605,513,800	\$	\$ 626,031,673	\$
9. Total <i>(Line11, Form 2)</i>	\$ 674,068,135	\$ 646,648,672	\$ 706,196,806	\$ 0	\$ 717,941,167	\$ 0
(STATE MCH BUDGET TOTAL)						

FORM NOTES FOR FORM 3

Notes have been added to update budget and expenditure amounts for FY09 and FY10. 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 federal award may change and FY11 expenditures are not final.

FIELD LEVEL NOTES

- 1. Section Number:** Form3_Main
Field Name: FedAllocExpended
Row Name: Federal Allocation
Column Name: Expended
Year: 2010
Field Note:
6/24/11: Budgeted amount is incorrect. It should be \$34,321,224; however system will not accept change in the "Budgeted" field.

The difference is greater than 10 % because of two reasons: 1) continued impact of readjustment to changes in indirect cost rates in FY08; and 2) 100% of unobligated (carryforward) was used in FY09.
- 2. Section Number:** Form3_Main
Field Name: FedAllocExpended
Row Name: Federal Allocation
Column Name: Expended
Year: 2009
Field Note:
Updated 6/24/11: Budgeted amount is incorrect. It should be \$34,437,266; however system will not accept change in the "Budgeted" field.

The difference is greater than 10 % because of two reasons: 1) Indirect costs were lower than anticipated and readjusted in FY08 and 2) 100% of unobligated (carryforward) was used in FY08.

Updated 7/13/10: Budgeted amount is incorrect. It should be \$34,437,266; however system will not accept change in the "Budgeted" field.

The difference is greater than 10 % because of two reasons: 1) Indirect costs were lower than anticipated and readjusted in FY08 and 2) 100% of unobligated (carryforward) was used in FY08.
- 3. Section Number:** Form3_Main
Field Name: UnobligatedBalanceExpended
Row Name: Unobligated Balance
Column Name: Expended
Year: 2010
Field Note:
6/24/11: Budgeted amount is incorrect. It should be \$11,497,250; however system will not accept change in the "Budgeted" field.

There is no difference between budgeted and expended in FY10 because 100% of unobligated funds were used.
- 4. Section Number:** Form3_Main
Field Name: UnobligatedBalanceExpended
Row Name: Unobligated Balance
Column Name: Expended
Year: 2009
Field Note:
Updated 7/13/10: Budgeted amount is incorrect. It should be \$10,538,576; however system will not accept change in the "Budgeted" field.

There is no difference between budgeted and expended in FY09 because 100% of unobligated funds were used.
- 5. Section Number:** Form3_Main
Field Name: StateMCHFundsExpended
Row Name: State Funds
Column Name: Expended
Year: 2010
Field Note:
6/24/11: Budgeted amount is incorrect. It should be \$54,527,818; however system will not accept change in the "Budgeted" field. Actual expenditures were 97% of the budgeted amount.
- 6. Section Number:** Form3_Main
Field Name: StateMCHFundsExpended
Row Name: State Funds
Column Name: Expended
Year: 2009
Field Note:
Updated 7/13/10: Budgeted amount is incorrect. It should be \$51,524,933; however system will not accept change in the "Budgeted" field. Actual expenditures were 94.31% of the budgeted amount.
- 7. Section Number:** Form3_Main
Field Name: OtherFundsExpended
Row Name: Other Funds
Column Name: Expended
Year: 2010
Field Note:
6/24/11: Budgeted amount is incorrect. It should be \$2,724,464; however system will not accept change in the "Budgeted" field.

There is no difference between budgeted and expended in FY10 because 100% of Other funds were used.
- 8. Section Number:** Form3_Main
Field Name: OtherFundsExpended
Row Name: Other Funds
Column Name: Expended
Year: 2009
Field Note:
Updated 7/13/10: Budgeted amount is incorrect. It should be \$500,330; however system will not accept change in the "Budgeted" field. The difference is no difference in the budgeted and expended in this category
- 9. Section Number:** Form3_Main

Field Name: ProgramIncomeExpended

Row Name: Program Income

Column Name: Expended

Year: 2010

Field Note:

6/24/11: Budgeted amount is incorrect. It should be \$2,662,461; however system will not accept change in the "Budgeted" field.

There is no difference between budgeted and expended in FY10 because 100% of unobligated funds were used.

10. Section Number: Form3_Main

Field Name: ProgramIncomeExpended

Row Name: Program Income

Column Name: Expended

Year: 2009

Field Note:

Updated 7/13/10: The difference is greater than 10 % because 100% of unobligated (carryforward) was used in FY09.

11. Section Number: Form3_Main

Field Name: OtherFedFundsExpended

Row Name: Other Federal Funds

Column Name: Expended

Year: 2009

Field Note:

Updated 7/13/10: Budgeted amount is incorrect. It should be \$650,113,122; however system will not accept change in the "Budgeted" field. With the updated budgeted amount, 91.20% of budgeted was expended in FY09.

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 2007		FY 2008		FY 2009	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	\$ 19,910,778	\$ 14,166,331	\$ 15,100,565	\$ 7,467,421	\$ 10,006,532	\$ 6,253,690
b. Infants < 1 year old	\$ 194,594	\$ 138,452	\$ 147,582	\$ 69,545	\$ 89,900	\$ 69,785
c. Children 1 to 22 years old	\$ 19,488,493	\$ 20,184,024	\$ 21,360,212	\$ 15,214,923	\$ 17,346,350	\$ 18,649,268
d. Children with Special Healthcare Needs	\$ 39,833,888	\$ 37,441,414	\$ 37,481,930	\$ 39,794,738	\$ 43,087,359	\$ 42,401,024
e. Others	\$ 9,483,642	\$ 6,747,521	\$ 7,192,503	\$ 9,849,346	\$ 12,954,783	\$ 9,536,761
f. Administration	\$ 10,699,118	\$ 5,406,068	\$ 8,320,103	\$ 5,542,503	\$ 6,066,512	\$ 5,944,622
g. SUBTOTAL	\$ 99,610,513	\$ 84,083,810	\$ 89,602,895	\$ 77,938,476	\$ 89,551,436	\$ 82,855,150
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	\$ 90,000		\$ 94,570		\$ 94,644	
c. CISS	\$ 0		\$ 0		\$ 0	
d. Abstinence Education	\$ 0		\$ 0		\$ 0	
e. Healthy Start	\$ 0		\$ 0		\$ 0	
f. EMSC	\$ 0		\$ 0		\$ 0	
g. WIC	\$ 491,856,423		\$ 512,913,733		\$ 553,930,301	
h. AIDS	\$ 0		\$ 0		\$ 0	
i. CDC	\$ 7,501,478		\$ 7,190,329		\$ 7,467,337	
j. Education	\$ 0		\$ 0		\$ 0	
k. Other						
Family Planning(T-X)	\$ 0		\$ 12,024,000		\$ 13,372,014	
NHSCPC/MaleInvolvem	\$ 0		\$ 0		\$ 915,712	
NHSCPC/MaleInvolveme	\$ 0		\$ 321,670		\$ 0	
Family Planning (T-X)	\$ 12,018,970		\$ 0		\$ 0	
NHSCPC/Male Involvem	\$ 518,965		\$ 0		\$ 0	
III. SUBTOTAL	\$ 511,985,836		\$ 532,544,302		\$ 575,780,008	

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 2010		FY 2011		FY 2012	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	\$ 8,476,492	\$ 4,236,601	\$ 4,776,187	\$	\$ 3,481,486	\$
b. Infants < 1 year old	\$ 99,777	\$ 42,704	\$ 57,725	\$	\$ 54,268	\$
c. Children 1 to 22 years old	\$ 24,268,091	\$ 19,159,536	\$ 20,525,721	\$	\$ 20,081,460	\$
d. Children with Special Healthcare Needs	\$ 49,669,910	\$ 48,687,608	\$ 51,907,849	\$	\$ 44,833,549	\$
e. Others	\$ 14,100,275	\$ 13,514,063	\$ 16,545,619	\$	\$ 17,336,457	\$
f. Administration	\$ 7,143,021	\$ 6,058,972	\$ 6,869,905	\$	\$ 6,122,274	\$
g. SUBTOTAL	\$ 103,757,566	\$ 91,699,484	\$ 100,683,006	\$ 0	\$ 91,909,494	\$ 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	\$ 94,644	\$ 93,713	\$ 133,669
c. CISS	\$ 0	\$ 0	\$ 0
d. Abstinence Education	\$ 0	\$ 0	\$ 0
e. Healthy Start	\$ 0	\$ 0	\$ 0
f. EMSC	\$ 0	\$ 0	\$ 0
g. WIC	\$ 554,091,746	\$ 581,324,119	\$ 598,926,315
h. AIDS	\$ 0	\$ 0	\$ 0
i. CDC	\$ 8,526,836	\$ 7,418,165	\$ 8,589,827
j. Education	\$ 0	\$ 0	\$ 0
k. Other			
Family Planning X	\$ 0	\$ 0	\$ 17,680,526
NHSCPC/Male Involvem	\$ 701,336	\$ 0	\$ 701,336
FamPlanning Title X	\$ 0	\$ 15,976,467	\$ 0
NHSCPC/MaleInvolve	\$ 0	\$ 701,336	\$ 0
Fam Planning Title X	\$ 6,896,007	\$ 0	\$ 0
III. SUBTOTAL	\$ 570,310,569	\$ 605,513,800	\$ 626,031,673

FORM NOTES FOR FORM 4

Notes have been added to update budget and expenditure amounts for FY09 and FY10. 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 federal award may change and FY11 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: 2012
Field Note:
6/24/11: Budgeted amounts for FY12 are estimated since the federal award may change and FY11 expenditures are not final.
2. **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.
3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenBudgeted
Row Name: Pregnant Women
Column Name: Budgeted
Year: 2010
Field Note:
Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.
4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenBudgeted
Row Name: Pregnant Women
Column Name: Budgeted
Year: 2009
Field Note:
Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.
5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenExpended
Row Name: Pregnant Women
Column Name: Expended
Year: 2010
Field Note:
6/24/11: Budgeted amount is incorrect. It should be \$4,884,972; however system will not accept change in the "Budgeted" field.

The 13% difference between budgeted and expended is a result of the continued utilization of CHIP Perinatal benefits for prenatal and post partum care that were previously provided primarily through Title V. Conservative budget adjustments were continued in FY10 to ensure funds remained available for use in contracts to cover limited benefits during application process for CHIP perinatal.
6. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: PregWomenExpended
Row Name: Pregnant Women
Column Name: Expended
Year: 2009
Field Note:
Updated 6/24/11: Budgeted amount is incorrect. It should be \$7,512,182; however system will not accept change in the "Budgeted" field.

The 17% difference between budgeted and expended is a result of the implementation of CHIP Perinatal benefits for prenatal and post partum care that were previously provided primarily through Title V. Conservative budget adjustments were continued in FY09 to ensure funds remained available for use in contracts as the full implementation of CHIP Perinatal benefits continued. The new program began January 2007.

Updated 7/13/10: Budgeted amount is incorrect. It should be \$8,263,181; however system will not accept change in the "Budgeted" field.

The 14% difference between budgeted and expended is a result of the implementation of CHIP Perinatal benefits for prenatal and post partum care that were previously provided primarily through Title V. Conservative budget adjustments were continued in FY09 to ensure funds remained available for use in contracts as the full implementation of CHIP Perinatal benefits continued. The new program began January 2007.
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: 2012
Field Note:
6/24/11: Budgeted amounts for FY12 are estimated since the federal award may change and FY11 expenditures are not final.
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: 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.
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: 2010
Field Note:
Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.
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: 2009

Field Note:

Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.

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: 2010

Field Note:

6/24/11: Budgeted amount is incorrect. It should be \$49,240; however system will not accept change in the "Budgeted" field.

The 13% difference between budgeted and expended is a result of the continued utilization of CHIP Perinatal benefits for infant care that was previously provided primarily through Title V. Conservative budget adjustments were continued in FY10 to ensure funds remained available for use in contracts to cover limited benefits during application process for CHIP.

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: 2009

Field Note:

Updated 6/24/11: Budgeted amount is incorrect. It should be \$83,829; however system will not accept change in the "Budgeted" field.

The 17% difference between budgeted and expended is a result of the implementation of CHIP Perinatal benefits for infant care that was previously provided primarily through Title V. Conservative budget adjustments were continued in FY09 to ensure funds remained available for use in contracts as the full implementation of CHIP Perinatal benefits continued. The new program began January 2007.

Updated 7/13/10: Budgeted amount is incorrect. It should be \$92,845; however system will not accept change in the "Budgeted" field.

The 14% difference between budgeted and expended is a result of the implementation of CHIP Perinatal benefits for infants that were previously provided primarily through Title V. Conservative budget adjustments were continued in FY09 to ensure funds remained available for use in contracts as the full implementation of CHIP Perinatal benefits continued. The new program began January 2007.

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: 2012

Field Note:

6/24/11: Budgeted amounts for FY12 are estimated since the federal award may change and FY11 expenditures are not final.

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: 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.

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: 2010

Field Note:

Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.

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: 2009

Field Note:

Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.

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: 2010

Field Note:

6/24/11: Budgeted amount is incorrect. It should be \$22,091,721; however system will not accept change in the "Budgeted" field.

The 13% difference between budgeted and expended is a result of the increased services available through CHIP and Medicaid. Conservative budget adjustments were made in FY10 to ensure funds remained available for use in Title V contracts as means of providing services during transitions to Medicaid and CHIP.

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: 2009

Field Note:

Updated 6/24/11: Budgeted amount is incorrect. It should be \$22,402,238; however system will not accept change in the "Budgeted" field.

The 17% difference between budgeted and expended is a result of the increased services available through CHIP and Medicaid. Conservative budget adjustments were made in FY09 to ensure funds remained available for use in Title V contracts as means of providing services during transitions to Medicaid and CHIP.

Updated 7/13/10: Budgeted amount is incorrect. It should be \$22,826,086; however system will not accept change in the "Budgeted" field.

The 14% difference between budgeted and expended is a result of the increased services available through CHIP and Medicaid. Conservative budget adjustments were

made in FY09 to ensure funds remained available for use in Title V contracts as means of providing services during transitions to Medicaid and CHIP.

19. **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.
20. **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.
21. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNBudgeted
Row Name: CSHCN
Column Name: Budgeted
Year: 2010
Field Note:
Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.
22. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNBudgeted
Row Name: CSHCN
Column Name: Budgeted
Year: 2009
Field Note:
Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.
23. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: CSHCNExpended
Row Name: CSHCN
Column Name: Expended
Year: 2009
Field Note:
Updated 6/24/11: Budgeted amount is incorrect. It should be \$50,933,788; however system will not accept change in the "Budgeted" field.

Updated 7/13/10: Budgeted amount is incorrect. It should be \$49,179,856; however system will not accept change in the "Budgeted" field.
24. **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.
25. **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.
26. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersBudgeted
Row Name: All Others
Column Name: Budgeted
Year: 2010
Field Note:
Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.
27. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersBudgeted
Row Name: All Others
Column Name: Budgeted
Year: 2009
Field Note:
Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.
28. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
Field Name: AllOthersExpended
Row Name: All Others
Column Name: Expended
Year: 2009
Field Note:
Updated 6/24/11: Budgeted amount is incorrect. It should be \$11,455,934; however system will not accept change in the "Budgeted" field.

Updated 7/13/10: Budgeted amount is incorrect. It should be \$11,827,612; however system will not accept change in the "Budgeted" field.
29. **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.
30. **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.

31. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminBudgeted

Row Name: Administration

Column Name: Budgeted

Year: 2010

Field Note:

Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.

32. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminBudgeted

Row Name: Administration

Column Name: Budgeted

Year: 2009

Field Note:

Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.

33. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminExpended

Row Name: Administration

Column Name: Expended

Year: 2010

Field Note:

6/24/11: Budgeted amount is incorrect. It should be \$6,986,240; however system will not accept change in the "Budgeted" field.

The 13% difference between budgeted and expended is a result of conservative budget adjustments implemented in FY10 to address changes in state revenue.

34. Section Number: Form4_I. Federal-State MCH Block Grant Partnership

Field Name: AdminExpended

Row Name: Administration

Column Name: Expended

Year: 2009

Field Note:

Updated 6/24/11: Budgeted amount is incorrect. It should be \$7,140,916 however system will not accept change in the "Budgeted" field.

Updated 7/13/10: Budgeted amount is incorrect. It should be \$7,339,306; however system will not accept change in the "Budgeted" field.

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 2007		FY 2008		FY 2009	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	\$ 66,853,452	\$ 56,842,542	\$ 60,256,085	\$ 59,218,583	\$ 60,389,544	\$ 59,920,100
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.)	\$ 7,301,473	\$ 6,900,212	\$ 6,782,290	\$ 4,811,555	\$ 7,080,578	\$ 4,910,786
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	\$ 14,777,623	\$ 10,946,194	\$ 12,848,404	\$ 9,098,132	\$ 12,214,400	\$ 11,235,664
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.)	\$ 10,677,965	\$ 9,394,862	\$ 9,716,116	\$ 4,810,206	\$ 9,866,914	\$ 6,788,600
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.)	\$ 99,610,513	\$ 84,083,810	\$ 89,602,895	\$ 77,938,476	\$ 89,551,436	\$ 82,855,150

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 2010		FY 2011		FY 2012	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	\$ 79,083,028	\$ 68,538,384	\$ 73,074,976		\$ 68,695,349	
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.)	\$ 6,339,478	\$ 5,045,617	\$ 5,876,806		\$ 5,057,173	
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	\$ 12,076,131	\$ 9,121,596	\$ 13,459,743		\$ 9,142,487	
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.)	\$ 6,258,929	\$ 8,993,887	\$ 8,271,481		\$ 9,014,485	
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.)	\$ 103,757,566	\$ 91,699,484	\$ 100,683,006	\$ 0	\$ 91,909,494	\$ 0

FORM NOTES FOR FORM 5

Notes have been added to update budget and expenditure amounts for FY09 and FY10. 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 federal award may change and FY11 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: 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.
2. **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.
3. **Section Number:** Form5_Main
Field Name: DirectHCBudgeted
Row Name: Direct Health Care Services
Column Name: Budgeted
Year: 2010
Field Note:
Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.
4. **Section Number:** Form5_Main
Field Name: DirectHCBudgeted
Row Name: Direct Health Care Services
Column Name: Budgeted
Year: 2009
Field Note:
Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.
5. **Section Number:** Form5_Main
Field Name: DirectHCExpended
Row Name: Direct Health Care Services
Column Name: Expended
Year: 2010
Field Note:
6/24/11: Budgeted amount is incorrect. It should be \$79,027,529; however system will not accept change in "Budgeted" field for FY10. Expenditures were 87% of budgeted amount.
6. **Section Number:** Form5_Main
Field Name: DirectHCExpended
Row Name: Direct Health Care Services
Column Name: Expended
Year: 2009
Field Note:
Updated 6/24/11: Budgeted amount is incorrect. It should be \$71,978,395; however system will not accept change in "Budgeted" field for FY10. Expenditures were 83% of budgeted amount.

Updated 7/14/10: Budgeted amount is incorrect. It should be \$72,237,321; however system will not accept change in "Budgeted" field. Expenditures were 85.79% of budgeted amount.
7. **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.
8. **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.
9. **Section Number:** Form5_Main
Field Name: EnablingBudgeted
Row Name: Enabling Services
Column Name: Budgeted
Year: 2010
Field Note:
Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.
10. **Section Number:** Form5_Main
Field Name: EnablingBudgeted
Row Name: Enabling Services
Column Name: Budgeted
Year: 2009
Field Note:
Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.
11. **Section Number:** Form5_Main
Field Name: EnablingExpended

Row Name: Enabling Services

Column Name: Expended

Year: 2010

Field Note:

6/24/11: Budgeted amount is incorrect. It should be \$5,817,801; however system will not accept change in "Budgeted" field for FY10. Expenditures were 87% of budgeted amount.

12. Section Number: Form5_Main

Field Name: EnablingExpended

Row Name: Enabling Services

Column Name: Expended

Year: 2009

Field Note:

Updated 6/24/11: Budgeted amount is incorrect. It should be \$5,899,031; however system will not accept change in "Budgeted" field for FY10. Expenditures were 83% of budgeted amount.

Updated 7/14/10: Budgeted amount is incorrect. It should be \$5,809,441; however system will not accept change in "Budgeted" field. Expenditures were 85.79% of budgeted amount.

13. 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.

14. 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.

15. Section Number: Form5_Main

Field Name: PopBasedBudgeted

Row Name: Population-Based Services

Column Name: Budgeted

Year: 2010

Field Note:

Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.

16. Section Number: Form5_Main

Field Name: PopBasedBudgeted

Row Name: Population-Based Services

Column Name: Budgeted

Year: 2009

Field Note:

Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.

17. Section Number: Form5_Main

Field Name: PopBasedExpended

Row Name: Population-Based Services

Column Name: Expended

Year: 2010

Field Note:

6/24/11: Budgeted amount is incorrect. It should be \$10,517,570; however system will not accept change in "Budgeted" field for FY10. Expenditures were 87% of budgeted amount.

18. Section Number: Form5_Main

Field Name: PopBasedExpended

Row Name: Population-Based Services

Column Name: Expended

Year: 2009

Field Note:

Updated 6/24/11: Budgeted amount is incorrect. It should be \$13,496,724; however system will not accept change in "Budgeted" field for FY10. Expenditures were 83% of budgeted amount.

Updated 7/14/10: Budgeted amount is incorrect. It should be \$13,305,456; however system will not accept change in "Budgeted" field. Expenditures were 85.79% of budgeted amount.

19. 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.

20. 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.

21. Section Number: Form5_Main

Field Name: InfrastrBuildBudgeted

Row Name: Infrastructure Building Services

Column Name: Budgeted

Year: 2010

Field Note:

Updated 7/11/09: The budgeted amount is an estimate since the Federal award may change in FY10. In addition, the final FY09 expenditures are not available at this time.

22. **Section Number:** Form5_Main
Field Name: InfrastrBuildBudgeted
Row Name: Infrastructure Building Services
Column Name: Budgeted
Year: 2009
Field Note:
Updated 7/11/08: The budgeted amount is an estimate since the Federal award may change in FY09. In addition, the final FY08 expenditures are not available at this time.
23. **Section Number:** Form5_Main
Field Name: InfrastrBuildExpended
Row Name: Infrastructure Building Services
Column Name: Expended
Year: 2010
Field Note:
6/24/11: Budgeted amount is incorrect. It should be \$10,370,316; however system will not accept change in "Budgeted" field for FY10. Expenditures were 87% of budgeted amount.
24. **Section Number:** Form5_Main
Field Name: InfrastrBuildExpended
Row Name: Infrastructure Building Services
Column Name: Expended
Year: 2009
Field Note:
Updated 6/24/11: Budgeted amount is incorrect. It should be \$8,154,735; however system will not accept change in "Budgeted" field for FY10. Expenditures were 83% of budgeted amount.

Updated 7/14/10: Budgeted amount is incorrect. It should be \$8,176,666; however system will not accept change in "Budgeted" field. Expenditures were 85.79% of budgeted amount.

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: 392,516

Reporting Year: 2010

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	390,611	99.5	99	9	9	100
Congenital Hypothyroidism	390,611	99.5	7,787	219	219	100
Galactosemia	390,611	99.5	631	3	3	100
Sickle Cell Disease	390,611	99.5	170	139	139	100
Other Screening (Specify)						
Biotinidase Deficiency	390,611	99.5	355	41	41	100
Cystic Fibrosis	390,611	99.5	371	59	59	100
Homocystinuria	390,611	99.5	126	0	0	
Maple Syrup Urine Disease	390,611	99.5	107	2	2	100
beta-ketothiolase deficiency	390,611	99.5	0	0	0	
Tyrosinemia Type I	390,611	99.5	74	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	390,611	99.5	103	9	9	100
Argininosuccinic Acidemia	390,611	99.5	79	2	2	100
Citrullinemia	390,611	99.5	0	1	1	100
Isovaleric Acidemia	390,611	99.5	316	1	1	100
Propionic Acidemia	390,611	99.5	0	1	1	100
Carnitine Uptake Defect	390,611	99.5	587	4	4	100
3-Methylcrotonyl-CoA Carboxylase Deficiency	390,611	99.5	221	10	10	100
Methylmalonic acidemia (Cbl A,B)	390,611	99.5	203	3	3	100
Multiple Carboxylase Deficiency	390,611	99.5	0	0	0	
Trifunctional Protein Deficiency	390,611	99.5	0	0	0	
Glutaric Acidemia Type I	390,611	99.5	156	7	7	100
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	390,611	99.5	4,296	29	29	100
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	390,611	99.5	205	14	14	100
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	390,611	99.5	44	0	0	

Final Version - 9-2-2010

3-Hydroxy 3-Methyl Glutaric Aciduria	390,611	99.5	0	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	390,611	99.5	0	1	1	100
Screening Programs for Older Children & Women (Specify Tests by name)						
Hearing Screening	2,609,444		43,489	0	0	
Vision Screening	2,701,769		227,621	0	0	
Spinal Screening	727,942		22,527	0	0	
(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

Data provided by the Newborn Screening Unit of the Department of State Health Services.

Screening Programs for Older Children & Women (hearing, vision, and spinal screening) provided by the Health Screening and Case Management Unit of the Department of State Health Services.

FIELD LEVEL NOTES

- Section Number:** Form6_Main
Field Name: BirthOccurence
Row Name: Total Births By Occurrence
Column Name: Total Births By Occurrence
Year: 2012
Field Note:
The number of occurent births in 2010 is provisional and subject to change.

- Section Number:** Form6_Main
Field Name: Galactosemia_Confirmed
Row Name: Galactosemia
Column Name: Confirmed Cases
Year: 2012
Field Note:
In 2009, all confirmed cases of all variant types of Galactosemia were reported. Only confirmed cases of Classical-type Galactosemia are reported for 2010.

- Section Number:** Form6_Other Screening Types
Field Name: Other
Row Name: All Rows
Column Name: All Columns
Year: 2012
Field Note:
In previous years, 21-Hydroxylase Deficient Congenital Adrenal Hyperplasia was reported as Congenital Adrenal Hyperplasia (Classical).

In 2009, positive screen results that were combined were divided by the number of combined groups and that number was reported in column (B) for each group.

Current reporting is below:

Trifunctional Protein Deficiency screen positives included with the Long-Chain Hydroxylacyl-CoA Dehydrogenase Deficiency total

Beta-ketothiolase Deficiency screen positives included with the 3-Methylcrotonyl-CoA Carboxylase Deficiency total

Hydroxymethylglutaric Aciduria screen positives included with the 3-Methylcrotonyl-CoA Carboxylase Deficiency total

Methylmalonic Acidemia mutase deficiency screen positives included with the Methylmalonic Acidemia total

Multiple Carboxylase Deficiency screen positive total included with the 3-Methylcrotonyl-CoA Carboxylase Deficiency total

Propionic Acidemia mutase deficiency screen positives included with the Methylmalonic Acidemia total

Citrullinemia screen positives included with the Argininosuccinic Acidemia total

- Section Number:** Form6_Screening Programs for Older Children and Women
Field Name: OtherWomen
Row Name: All Rows
Column Name: All Columns
Year: 2012
Field Note:
Data for hearing, vision, and spinal screening among older children is not available by calendar year and is therefore presented for FY2010.

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	2005	2006	2007	2008	2009
Pregnant Women	230,545	226,089	159,425	136,950	97,641
Infants < 1 year old	388,394	391,888	414,161	416,508	408,374
Children 1 to 22 years old	5,545,444	5,488,402	6,073,452	6,093,947	6,186,914
Children with Special Healthcare Needs	90,375	79,874	81,622	80,180	98,607
Others	162,603	174,977	137,412	136,855	123,886
Total	6,417,361	6,361,230	6,866,072	6,864,440	6,915,422

Reporting Year: 2010

Types of Individuals Served	TITLE V	PRIMARY SOURCES OF COVERAGE				
	(A) Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
Pregnant Women	67,232					100.0
Infants < 1 year old	394,736					100.0
Children 1 to 22 years old	6,140,797					100.0
Children with Special Healthcare Needs	110,513	70.0	2.1	13.2	14.7	
Others	254,649					100.0
TOTAL	6,967,927					

FORM NOTES FOR FORM 7

None

FIELD LEVEL NOTES

None

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: 2010

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	387,791	271,937	44,640	937	15,500	468	5,335	48,974
Title V Served	22,826	16,007	2,628	55	912	28	314	2,882
Eligible for Title XIX	220,899	154,905	25,428	534	8,829	267	3,039	27,897
INFANTS								
Total Infants in State	405,471	345,043	44,678	223	3,698	111		11,718
Title V Served	394,736	335,908	43,495	217	3,600	108		11,408
Eligible for Title XIX	408,120	347,297	44,970	224	3,722	112		11,795

II. UNDUPLICATED COUNT BY ETHNICITY

	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	HISPANIC OR LATINO (Sub-categories by country or area of origin)				
				(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	197,448	190,343		140,643	518	1,731		47,451
Title V Served	11,622	11,204		8,278	30	102		2,794
Eligible for Title XIX	112,473	108,426		80,115	295	986		27,030
INFANTS								
Total Infants in State	192,277	213,194		157,528	580	1,939		53,147
Title V Served	187,186	207,550		153,357	565	1,888		51,740
Eligible for Title XIX	193,533	214,587		158,557	584	1,952		53,494

FORM NOTES FOR FORM 8

2010 total deliveries in state: 2010 provisional race/ethnicity data (from live resident births and fetal deaths).

Title V Served (Deliveries): Sum of FY 2010 Prenatal Counts from MCH, SDI and TWICES.

Eligible for Title XIX (Deliveries) - Susan Burek (HHSC) - Medicaid Deliveries for 2010.

Total Infants in State from Center for Health Statistics 2010 Estimation
Title V Served (Infants) - 2010 Provisional births occurring in Texas provided by Vital Statistics.

Eligible for Title XIX (Infants) - trend from 2003 to current.

FIELD LEVEL NOTES

- 1. Section Number:** Form8_I. Unduplicated Count By Race
Field Name: DeliveriesTotal_More
Row Name: Total Deliveries in State
Column Name: More Than One Race Reported
Year: 2012
Field Note:
In previous years, total deliveries in state were projections using race/ethnicity percents applied to population estimates provided by Vital Statistics. Provisional 2010 birth and fetal death data were available this year and provided information on clients who selected more than one race.
- 2. Section Number:** Form8_I. Unduplicated Count By Race
Field Name: DeliveriesTitleV_More
Row Name: Title V Served
Column Name: More Than One Race Reported
Year: 2012
Field Note:
In previous years, total deliveries in state were projections using race/ethnicity percents applied to population estimates provided by Vital Statistics. Provisional 2010 birth and fetal death data were available this year and provided information on clients who selected more than one race.
- 3. Section Number:** Form8_I. Unduplicated Count By Race
Field Name: DeliveriesTitleXIX_More
Row Name: Eligible for Title XIX
Column Name: More Than One Race Reported
Year: 2012
Field Note:
In previous years, total deliveries in state were projections using race/ethnicity percents applied to population estimates provided by Vital Statistics. Provisional 2010 birth and fetal death data were available this year and provided information on clients who selected more than one race.
- 4. Section Number:** Form8_I. Unduplicated Count By Race
Field Name: InfantsTotal_All
Row Name: Total Infants in State
Column Name: Total All Races
Year: 2012
Field Note:
The total number of infants in state is an estimation provided by the Center for Health Statistics. These numbers may be underestimated, which is why they are lower than the number of infants eligible for Title XIX.
- 5. Section Number:** Form8_I. Unduplicated Count By Race
Field Name: InfantsTitleXIX_All
Row Name: Eligible for Title XIX
Column Name: Total All Races
Year: 2012
Field Note:
The total number of infants in state is an estimation provided by the Center for Health Statistics. These numbers may be underestimated, which is why they are lower than the number of infants eligible for Title XIX.

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TX

	FY 2012	FY 2011	FY 2010	FY 2009	FY 2008
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 2012	FY 2011	FY 2010	FY 2009	FY 2008
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				
4. Contact Person's Telephone Number	(512) 483-5110	(512) 483-5110	(512) 483-5110	512-533-2150	512-533-2150
5. Contact Person's Email	beth.wick@hhsc.state.tx.us	beth.wick@hhsc.state.tx.us	beth.wick@hhsc.state.tx.us		
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	214319	129992	132763

FORM NOTES FOR FORM 9

None

FIELD LEVEL NOTES

1. **Section Number:** Form9_Main

Field Name: hnumber_2

Row Name: State MCH toll-free hotline telephone number

Column Name: FY

Year: 2010

Field Note:

The following information is available on the HHSC website at <http://www.hhsc.state.tx.us/Help/index.html>:

If you can't connect to 2-1-1, call us toll-free at 1-877-541-7905. You also can visit the 2-1-1 Texas website (www.211texas.org) to find the phone number to your local 2-1-1 Area Information Center.

You might not be able to connect to 2-1-1 if:

You are calling from outside of Texas.

Your cell phone won't dial 2-1-1.

You use voice-over-IP (use the Internet to make calls).

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2012
[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; Titles V, X, and XX Family Planning 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 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)	\$ <u>33,678,798</u>
3. Unobligated balance (Line 2, Form 2)	\$ <u>9,306,829</u>
4. State Funds (Line 3, Form 2)	\$ <u>46,105,185</u>
5. Local MCH Funds (Line 4, Form 2)	\$ <u>0</u>
6. Other Funds (Line 5, Form 2)	\$ <u>290,902</u>
7. Program Income (Line 6, Form 2)	\$ <u>2,527,780</u>
8. Total Federal-State Partnership (Line 8, Form 2)	\$ <u>91,909,494</u>

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	<u>67,232</u>
b. Infants < 1 year old	<u>394,736</u>
c. Children 1 to 22 years old	<u>6,140,797</u>
d. CSHCN	<u>110,513</u>
e. Others	<u>254,649</u>

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

For FY10, Title V continued to award more than 175 service contracts to local health care providers through a competitive request for proposals process. In FY10, a total of 924,000 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 care, family planning services, dysplasia services, 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. Family Planning Services provides reproductive care to support general wellness and reproductive health to women and men through the provision of an annual exam, education/counseling, laboratory testing, contraception, and diagnosis and treatment of sexually transmitted infections. Dysplasia services include initial and follow-up visits, colposcopy, biopsy, and conservative treatments for cervical cancer. 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)

FY10 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 FY10, an estimated 6,043,927 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, MSW, LMSW
Title State Title V Director
Address P.O. Box 149347 - MC1922
City Austin
State TX
Zip 78714-9347
Phone 512-458-2184
Fax 512-458-7658
Email sam.cooper@dshs.state.tx.us
Web www.dshs.state.tx.us

13. The children with special health care needs (CSHCN) contact person:

Name Carol Labaj, RN, BSN
Title Interim State Title V CSHCN Director
Address P.O. Box 149347 - MC1938
City Austin
State TX
Zip 78714-9347
Phone 512-458-3104
Fax 512-458-7328
Email Carol.Labaj@dshs.state.tx.us
Web 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

Natality data in Texas is final for 2008 and provisional for 2009. All data reported for 2010 is estimated. Estimates are linear projections based on data from 1991 through 2008 (unless otherwise noted in a field level note). Mortality data in Texas is final for 2008 and provisional for 2009. All data reported for 2010 is estimated. Estimates are linear projections based on data from 1991 through 2008 (unless otherwise noted in a field level note). Population estimates through 2009 and 2010 projections are provided by the Texas Office of the State Demographer (TxSDC). A summary of these data can be found on the Texas DSHS website (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>). Projections of the 2010 population are produced by TxSDC using a model of projected births and deaths, rather than actual records. Both estimation and projection models use estimates of migration rates produced by the TxSDC. The Texas Health and Human Services Commission (HHSC) has designated the "2000 - 2007 Scenario" to be the current standard for HHSC agency population projections. The 2000-2007 projection scenario provides a scenario that takes into account post-2000 population trends. (http://txsdc.utsa.edu/tpepp/2008projections/2008_Texas_County_Projection_Methodology.pdf) Current population estimates developed through 2009 using actual records (births, deaths, school enrollment, voter registration, etc) have revealed that population projections using the 2000-2007 scenario may be an underestimate. As a result, indicators using 2010 population projections as a denominator are likely to be overestimated. Annual performance objectives from 2011 through 2015 have been adjusted for changing trends where necessary.

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.

	Annual Objective and Performance Data				
	2006	2007	2008	2009	2010
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	370	433	470	524	554
Denominator	370	433	470	524	554
Data Source			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.					
<i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Final	Final

	Annual Objective and Performance Data				
	2011	2012	2013	2014	2015
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- 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.
- Section Number:** Form11_Performance Measure #1
Field Name: PM01
Row Name:
Column Name:
Year: 2009
Field Note:
Denominator is number of confirmed cases as indicated on Form 6. In the previous application, the 2009 number of confirmed cases included all types of Galactosemia. This number has been adjusted to include confirmed cases of only classical-type Galactosemia, as directed by the Block Grant guidance.
- Section Number:** Form11_Performance Measure #1
Field Name: PM01
Row Name:
Column Name:
Year: 2008
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				
	2006	2007	2008	2009	2010
Annual Performance Objective	57.4	57.5	58	58.1	58.2
Annual Indicator	57.0	57.9	57.9	57.9	57.9
Numerator	142,384	450,786	450,786	450,786	450,786
Denominator	249,840	778,339	778,339	778,339	778,339
Data Source			National Survey of CSHCN	National Survey of CSHCN	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				
	2011	2012	2013	2014	2015
Annual Performance Objective	58.3	58.4	58.5	58.6	58.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #2

Field Name: PM02

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 NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

2. **Section Number:** Form11_Performance Measure #2

Field Name: PM02

Row Name:

Column Name:

Year: 2009

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 NPM02 indicator for both the 2001 and 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

3. **Section Number:** Form11_Performance Measure #2

Field Name: PM02

Row Name:

Column Name:

Year: 2008

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 NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

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)

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	58.7	58.8	46.4	46.5	46.6
Annual Indicator	58.3	46.3	46.3	46.3	46.3
Numerator	399,631	351,768	351,768	351,768	351,768
Denominator	685,206	759,974	759,974	759,974	759,974
Data Source			National Survey of CSHCN	National Survey of CSHCN	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.					
<i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Final	Final

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	46.7	46.8	47	47.1	47.1
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- 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 NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.
- Section Number:** Form11_Performance Measure #3
Field Name: PM03
Row Name:
Column Name:
Year: 2009
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 NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Numerator and denominator are weighted estimates.
- Section Number:** Form11_Performance Measure #3
Field Name: PM03
Row Name:
Column Name:
Year: 2008
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 NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Numerator and denominator are weighted estimates.

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				
	2006	2007	2008	2009	2010
Annual Performance Objective	54	54.1	58.3	58.4	58.5
Annual Indicator	52.9	58.2	58.2	58.2	58.2
Numerator	366,173	462,528	462,528	462,528	462,528
Denominator	692,198	795,137	795,137	795,137	795,137
Data Source			National Survey of CSHCN	National Survey of CSHCN	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				
	2011	2012	2013	2014	2015
Annual Performance Objective	58.6	58.7	58.8	58.9	58.9
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #4

Field Name: PM04

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.

2. **Section Number:** Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2009

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. Numerator and denominator are weighted estimates.

3. **Section Number:** Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2008

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. Numerator and denominator are weighted estimates.

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				
	2006	2007	2008	2009	2010
Annual Performance Objective	77.2	77.3	88.3	88.4	88.5
Annual Indicator	76.8	88.2	88.2	88.2	88.2
Numerator	193,670	706,914	706,914	706,914	706,914
Denominator	252,253	801,141	801,141	801,141	801,141
Data Source			National Survey of CSHCN	National Survey of CSHCN	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				
	2011	2012	2013	2014	2015
Annual Performance Objective	88.6	88.7	88.8	88.9	88.9
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- 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.

- Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2009

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. Numerator and denominator are weighted estimates.

- Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2008

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. Numerator and denominator are weighted estimates.

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					
	2006	2007	2008	2009	2010
Annual Performance Objective	<u>5.8</u>	<u>5.8</u>	<u>37.2</u>	<u>37.3</u>	<u>37.4</u>
Annual Indicator	<u>5.8</u>	<u>37.1</u>	<u>37.1</u>	<u>37.1</u>	<u>37.1</u>
Numerator		<u>107,424</u>	<u>107,424</u>	<u>107,424</u>	<u>107,424</u>
Denominator		<u>289,879</u>	<u>289,879</u>	<u>289,879</u>	<u>289,879</u>
Data Source			National Survey of CSHCN	National Survey of CSHCN	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.					
<i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data					
	2011	2012	2013	2014	2015
Annual Performance Objective	<u>37.5</u>	<u>37.6</u>	<u>37.7</u>	<u>37.8</u>	<u>37.9</u>
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- 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.

- Section Number:** Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2009

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. Numerator and denominator are weighted estimates.

- Section Number:** Form11_Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2008

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. Numerator and denominator are weighted estimates.

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.

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	<u>80</u>	<u>80</u>	<u>80</u>	<u>80</u>	<u>81</u>
Annual Indicator	<u>76.7</u>	<u>78.2</u>	<u>78.6</u>	<u>74.4</u>	<u>78.2</u>
Numerator	<u>412,110</u>	<u>427,369</u>	<u>431,060</u>	<u>412,459</u>	<u>441,810</u>
Denominator	<u>537,301</u>	<u>546,507</u>	<u>548,422</u>	<u>554,380</u>	<u>564,742</u>
Data Source			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.					
<i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Final	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	<u>80</u>	<u>80</u>	<u>80.5</u>	<u>80.5</u>	<u>81</u>
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #7
Field Name: PM07
Row Name:
Column Name:
Year: 2010
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 2006-2009 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.
- Section Number:** Form11_Performance Measure #7
Field Name: PM07
Row Name:
Column Name:
Year: 2009
Field Note:
 This indicator has been adjusted for final data. The percent immunized are from the National Immunization Survey <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart> (accessed on 03/25/2011). Data from 2006-2009 are final.
- Section Number:** Form11_Performance Measure #7
Field Name: PM07
Row Name:
Column Name:
Year: 2008
Field Note:
 The percent immunized are from the National Immunization Survey <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart> (accessed on 05/11/2010). Data from 2006-2009 are final.

PERFORMANCE MEASURE # 08

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	37	37	32	32	32
Annual Indicator	33.7	34.9	34.9	33.1	35.1
Numerator	17,918	18,449	18,934	17,907	18,225
Denominator	531,239	528,403	542,343	540,995	519,372
Data Source			Nativity Data and Office of State Demographer	Nativity Data and Office of State Demographer	Nativity Data and Office of State Demographer
<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>(Explain data in a year note. See Guidance, Appendix IX.)</p>					
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	34	34	34	33.5	33.5
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #8
Field Name: PM08
Row Name:
Column Name:
Year: 2010
Field Note:
 Natality data reported for 2010 is estimated. Estimates are linear projections of based on data from 1991 through 2008.
 Denominator data is projected by the Office of the State Demographer.
- Section Number:** Form11_Performance Measure #8
Field Name: PM08
Row Name:
Column Name:
Year: 2009
Field Note:
 2009 natality data is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.
 Denominator data provided by the Office of the State Demographer.
- Section Number:** Form11_Performance Measure #8
Field Name: PM08
Row Name:
Column Name:
Year: 2008
Field Note:
 2008 Natality data is final. This indicator has been adjusted for final data.
 Denominator data provided 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				
	2006	2007	2008	2009	2010
Annual Performance Objective	35	35	34.4	37	37
Annual Indicator	22.7	22.7	34.4	34.4	34.4
Numerator	71,225	72,898	122,241	126,694	128,530
Denominator	313,768	321,135	355,351	368,296	373,633
Data Source			Texas Education Agency	Texas Education Agency	Texas Education Agency
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. (Explain data in a year note. See Guidance, Appendix IX.)					
Is the Data Provisional or Final?				Final	Final

	Annual Objective and Performance Data				
	2011	2012	2013	2014	2015
Annual Performance Objective	37	37	39	39	39
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- 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.

- Section Number:** Form11_Performance Measure #9

Field Name: PM09

Row Name:

Column Name:

Year: 2009

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 2009 (Source: Texas Education Agency; <http://www.tea.state.tx.us/student.assessment/reporting/>).

- Section Number:** Form11_Performance Measure #9

Field Name: PM09

Row Name:

Column Name:

Year: 2008

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 2008 (Source: Texas Education Agency; <http://www.tea.state.tx.us/student.assessment/reporting/>).

PERFORMANCE MEASURE # 10

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	5.4	5.1	4.7	4.7	4.6
Annual Indicator	4.9	4.9	3.5	3.7	4.1
Numerator	260	261	188	200	210
Denominator	5,287,340	5,332,129	5,384,151	5,449,069	5,117,214
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
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?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	4	3.8	3.6	3.5	3.4
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #10
Field Name: PM10
Row Name:
Column Name:
Year: 2010
Field Note:
Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 1999 through 2008.
Denominator data is projected by the Office of the State Demographer.
- Section Number:** Form11_Performance Measure #10
Field Name: PM10
Row Name:
Column Name:
Year: 2009
Field Note:
Mortality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.
Denominator data provided by the Office of the State Demographer.
- Section Number:** Form11_Performance Measure #10
Field Name: PM10
Row Name:
Column Name:
Year: 2008
Field Note:
2008 Mortality data is final. This indicator has been adjusted for final data.
Denominator data provided by the Office of the State Demographer.

PERFORMANCE MEASURE # 11

The percent of mothers who breastfeed their infants at 6 months of age.

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	38	38.5	37	48.5	56
Annual Indicator	34.9	46.1	46.9	48.5	50.2
Numerator		182,673	189,896	194,919	208,185
Denominator		396,167	405,242	401,610	414,640
Data Source			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. <i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	51	51.5	52	52.5	53
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- 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.

- Section Number:** Form11_Performance Measure #11

Field Name: PM11

Row Name:

Column Name:

Year: 2009

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 and are provisional for 2009. Numerator data are calculated by multiplying the percent from the National Immunization Survey and the total number of live births.

- Section Number:** Form11_Performance Measure #11

Field Name: PM11

Row Name:

Column Name:

Year: 2008

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. Natality data is final for 2008. Numerator data are calculated by multiplying the percent from the National Immunization Survey and the total number of live births. This indicator has been adjusted for final data.

PERFORMANCE MEASURE # 12

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	90	92	96	94	94
Annual Indicator	91.0	92.5	93.1	95.4	88.2
Numerator	366,442	379,007	383,596	389,612	376,311
Denominator	402,711	409,639	412,099	408,391	426,415
Data Source			Newborn Screening Database and Natality Data	Newborn Screening Database and Natality Data	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

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	94	94.5	95	95.5	96
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2010

Field Note:

Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence. Final natality data are available for 2008 only. In 2010, denominator data are estimated using a linear projection using natality data from 1996 through 2008.

- Section Number:** Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2009

Field Note:

Numerator data are final. Denominator data is provisional. This indicator has been adjusted for provisional data. In the previous grant application, the denominator was based on a linear trend. Denominator includes all births in Texas regardless of maternal state of residence.

- Section Number:** Form11_Performance Measure #12

Field Name: PM12

Row Name:

Column Name:

Year: 2008

Field Note:

Numerator and denominator data are final. This indicator has been adjusted for final data. Denominator includes all births in Texas regardless of maternal state of residence.

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	20	19.9	20	20	19.5
Annual Indicator	18.9	21.4	17.9	16.5	17.7
Numerator	1,224,279	1,434,980	1,216,968	1,149,840	1,245,777
Denominator	6,476,859	6,720,386	6,783,441	6,966,193	7,034,956
Data Source			US Census Bureau, Current Population Survey	US Census Bureau, Current Population Survey	US Census Bureau, Current Population Survey
<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>(Explain data in a year note. See Guidance, Appendix IX.)</p>					
Is the Data Provisional or Final?				Final	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	17	17	17	16.5	16
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #13
Field Name: PM13
Row Name:
Column Name:
Year: 2010
Field Note:
 Numerator and denominator data for FY2010 are linear projections based on data from 2003 through 2009 from the US Census Bureau, Current Population Survey, Annual Social and Economic Supplement (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).
- Section Number:** Form11_Performance Measure #13
Field Name: PM13
Row Name:
Column Name:
Year: 2009
Field Note:
 Data presented in the columns from 2006 through 2009 are correct and final. This indicator has been adjusted for final data. Numerator and denominator data are provided by the US Census Bureau, Current Population Survey, Annual Social and Economic Supplement(http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).
- Section Number:** Form11_Performance Measure #13
Field Name: PM13
Row Name:
Column Name:
Year: 2008
Field Note:
 Data presented in the columns from 2006 through 2009 are correct and final. Numerator and denominator data are provided by the US Census Bureau, Current Population Survey, Annual Social and Economic Supplement(http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

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.

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	<u>23</u>	<u>22</u>	<u>21</u>	<u>23</u>	<u>29</u>
Annual Indicator	<u>23.9</u>	<u>24.1</u>	<u>31.5</u>	<u>31.4</u>	<u>31.3</u>
Numerator	<u>160,793</u>	<u>164,231</u>	<u>146,631</u>	<u>140,676</u>	<u>142,942</u>
Denominator	<u>671,445</u>	<u>680,571</u>	<u>465,319</u>	<u>448,039</u>	<u>456,124</u>
Data Source			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.					
<i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Final	Final

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	<u>31</u>	<u>30.9</u>	<u>30.8</u>	<u>30.7</u>	<u>30.6</u>
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- 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.

- Section Number:** Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2009

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.

This indicator has been adjusted for final data. Denominator data are all children ages two to five years of age. These data are reported through certification data provided by the WIC program. Numerator data are all children with a BMI at or above the 85th percentile as noted in the Health and Nutrition Risk Tables provided by the WIC program.

- Section Number:** Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2008

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 # 15

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	<u>7.3</u>	<u>7.2</u>	<u>7.5</u>	<u>8</u>	<u>8</u>
Annual Indicator	<u>7.9</u>	<u>8.3</u>	<u>6.0</u>	<u>7.2</u>	<u>7.0</u>
Numerator		<u>32,882</u>	<u>24,517</u>	<u>28,755</u>	<u>28,698</u>
Denominator		<u>396,167</u>	<u>405,242</u>	<u>401,610</u>	<u>411,254</u>
Data Source			PRAMS and Nativity Data	PRAMS and Nativity Data	PRAMS and 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.					
<i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	<u>6.9</u>	<u>6.8</u>	<u>6.6</u>	<u>6.4</u>	<u>6.2</u>
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #15
Field Name: PM15
Row Name:
Column Name:
Year: 2010
Field Note:
 PRAMS data for Texas are only available through 2009. The estimate for 2010 is a linear projection based on PRAMS data from 2002 through 2009. Denominator data are all live births. Birth estimates for 2010 are based on a linear projection using natality data from 2005 through 2008. Numerator data are calculated by multiplying the percent from PRAMS and the total number of live births.
- Section Number:** Form11_Performance Measure #15
Field Name: PM15
Row Name:
Column Name:
Year: 2009
Field Note:
 PRAMS data for Texas are available through 2009. Denominator data are all live births. Natality data for 2009 is provisional. This indicator has been adjusted for final PRAMS data and provisional birth data. In the previous grant application, the denominator was based on a linear trend. Numerator data are calculated by multiplying the percent from PRAMS and the total number of live births.
- Section Number:** Form11_Performance Measure #15
Field Name: PM15
Row Name:
Column Name:
Year: 2008
Field Note:
 PRAMS data for Texas are available through 2009. Denominator data are all live births. Natality data are final for 2008. This indicator has been adjusted for final data. Numerator data are calculated by multiplying the percent from PRAMS and the total number of live births.

PERFORMANCE MEASURE # 16

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	7.8	7.6	6	5.5	5.2
Annual Indicator	6.9	6.4	7.2	8.7	7.8
Numerator	125	118	134	163	141
Denominator	1,810,309	1,840,936	1,866,100	1,882,929	1,810,902
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
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?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	7.5	7.4	7.3	7.2	7.1
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #16
Field Name: PM16
Row Name:
Column Name:
Year: 2010
Field Note:
Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 2003 through 2008.
Denominator data is projected by the Office of the State Demographer.
- Section Number:** Form11_Performance Measure #16
Field Name: PM16
Row Name:
Column Name:
Year: 2009
Field Note:
Mortality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.
Denominator data provided by the Office of the State Demographer.
- Section Number:** Form11_Performance Measure #16
Field Name: PM16
Row Name:
Column Name:
Year: 2008
Field Note:
Mortality data reported for 2008 are final. This indicator has been adjusted for final data.
Denominator data provided by the Office of the State Demographer.

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>				
	2006	2007	2008	2009	2010
Annual Performance Objective	55	55	52	52	52
Annual Indicator	49.4	48.2	50.2	47.0	47.9
Numerator	2,786	2,849	2,946	2,775	2,999
Denominator	5,639	5,913	5,865	5,906	6,263
Data Source			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.

(Explain data in a year note. See Guidance, Appendix IX.)

Is the Data Provisional or Final?

Provisional Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	50	50	51	51.5	52
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #17

Field Name: PM17

Row Name:

Column Name:

Year: 2010

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 2010 are estimates. Estimates are linear projections based on data from 1996 through 2008.

- Section Number:** Form11_Performance Measure #17

Field Name: PM17

Row Name:

Column Name:

Year: 2009

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 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

- Section Number:** Form11_Performance Measure #17

Field Name: PM17

Row Name:

Column Name:

Year: 2008

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 2008 are final. This indicator has been adjusted for final data.

PERFORMANCE MEASURE # 18

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	85	85	73	74	66
Annual Indicator	65.4	62.6	57.9	58.0	55.9
Numerator	255,429	249,155	234,829	232,782	230,085
Denominator	390,702	398,319	405,242	401,610	411,254
Data Source			Nativity Data	Nativity Data	Nativity Data
Check this box if you cannot report the numerator because					
1. There are fewer than 5 events over the last year, and					
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
(Explain data in a year note. See Guidance, Appendix IX.)					
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	58	58	58.2	58.4	58.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

- Section Number:** Form11_Performance Measure #18
Field Name: PM18
Row Name:
Column Name:
Year: 2010
Field Note:
 In 2005, Texas implemented the U.S. Certificate of Live Birth, 2003. This change had a significant impact on measure of prenatal care utilization. Estimates for 2010 are linear projections based on data from 2005 through 2008.
- Section Number:** Form11_Performance Measure #18
Field Name: PM18
Row Name:
Column Name:
Year: 2009
Field Note:
 Natality data from 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.
- Section Number:** Form11_Performance Measure #18
Field Name: PM18
Row Name:
Column Name:
Year: 2008
Field Note:
 Natality data from 2008 is final. This indicator has been adjusted for final data.

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

Natality data in Texas is final for 2008 and provisional for 2009. All data reported for 2010 is estimated. Estimates are linear projections based on data from 1991 through 2008 (unless otherwise noted in a field level note). Mortality data in Texas is final for 2008 and provisional for 2009. All data reported for 2010 is estimated. Estimates are linear projections based on data from 1991 through 2008 (unless otherwise noted in a field level note). Population estimates through 2009 and 2010 projections are provided by the Texas Office of the State Demographer (TxSDC). A summary of these data can be found on the Texas DSHS website (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>). Projections of the 2010 population are produced by TxSDC using a model of projected births and deaths, rather than actual records. Both estimation and projection models use estimates of migration rates produced by the TxSDC. The Texas Health and Human Services Commission (HHSC) has designated the "2000 - 2007 Scenario" to be the current standard for HHSC agency population projections. The 2000-2007 projection scenario provides a scenario that takes into account post-2000 population trends. (http://txsdc.utsa.edu/tpepp/2008projections/2008_Texas_County_Projection_Methodology.pdf) Current population estimates developed through 2009 using actual records (births, deaths, school enrollment, voter registration, etc) have revealed that population projections using the 2000-2007 scenario may be an underestimate. As a result, indicators using 2010 population projections as a denominator are likely to be overestimated. Annual performance objectives from 2011 through 2015 have been adjusted for changing trends where necessary.

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				
	2006	2007	2008	2009	2010
Annual Performance Objective	95	90	90	85	85
Annual Indicator	100.1	99.4	100.4	97.8	97.0
Numerator	1,619	1,608	1,624	1,582	1,568
Denominator	1,617	1,617	1,617	1,617	1,617
Data Source			Permanency Planning and Family Based Alt. Report	Permanency Planning and Family Based Alt. Report	Permanency Planning and Family Based Alt. Report
Is the Data Provisional or Final?				Final	Provisional

	Annual Objective and Performance Data				
	2011	2012	2013	2014	2015
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: 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 Services facilities.
- Section Number:** Form11_State Performance Measure #1
Field Name: SM1
Row Name:
Column Name:
Year: 2009
Field Note:
 Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature February 2010.

The FY09 number decreased from the base year 2003. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments. The number of children in Intermediate Care Facilities/Mental Retardation remained steady with slight decreases in other facility types.
- Section Number:** Form11_State Performance Measure #1
Field Name: SM1
Row Name:
Column Name:
Year: 2008
Field Note:
 Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2008.

The FY08 number exceeds the base year 2003. While the total number of children in institutions as defined by SB368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments with two exceptions. The number of children in state mental retardation facilities, including state schools is increasing and the number of children in Department of Family and Protective Services (DFPS) is increasing.

STATE PERFORMANCE MEASURE # 2 - REPORTING YEAR

Rate of excess feto-infant mortality in Texas.

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Indicator	_____	_____	1.6	1.5	1.5
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
Data Source			Natality and Mortality Data	Natality and Mortality Data	Natality and Mortality Data
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	1.5	1.5	1.4	1.4	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: 2010

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)

Natality, Mortality, and Fetal death data for 2010 are estimated. Estimates are based on a linear trend of final data from 2005-2008 and provisional data from 2009.

Indicator = 7.4/1,000 live births (Texas) - 5.9/1,000 live births (Reference) = 1.5/1,000 live births

2. Section Number: Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2009

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)

Natality, Mortality, and Fetal death data for 2010 are provisional.

Indicator = 7.4/1,000 live births (Texas) - 5.9/1,000 live births (Reference) = 1.5/1,000 live births

3. Section Number: Form11_State Performance Measure #2

Field Name: SM2

Row Name:

Column Name:

Year: 2008

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)

Natality, Mortality, and Fetal death data for 2008 are final.

Indicator = 7.5/1,000 live births (Texas) - 5.9/1,000 live births (Reference) = 1.6/1,000 live births

STATE PERFORMANCE MEASURE # 3 - REPORTING YEAR

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
Data Source					
Is the Data Provisional or Final?					

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	_____	_____	_____	_____	_____
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: SM3

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. The survey is currently being administered. The results of the survey will be available and ready for dissemination by September 1, 2011.

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>				
	2006	2007	2008	2009	2010
Annual Performance Objective	17.5	17	16.5	16	15.5
Annual Indicator	15.9	18.1	15.7	15.0	14.7
Numerator	733,256	846,808	743,014	720,955	725,788
Denominator	4,613,620	4,666,871	4,732,576	4,806,369	4,937,333
Data Source			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>				
	2011	2012	2013	2014	2015
Annual Performance Objective	14.5	14.5	14	13.5	13
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: 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. BRFSS data for 2010 is estimated. Estimates are linear projections based on data from 2005 through 2009. Denominator data is projected by the Office of the State Demographer.
- Section Number:** Form11_State Performance Measure #4
Field Name: SM4
Row Name:
Column Name:
Year: 2009
Field Note:
 This indicator has been adjusted for final data. BRFSS is a sample survey, therefore, the numerator and denominator are not available. The annual indicator is the point estimate of the data collected after weighting. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by multiplying the percent from BRFSS and the total number of women 18 to 44 years of age.
- Section Number:** Form11_State Performance Measure #4
Field Name: SM4
Row Name:
Column Name:
Year: 2008
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. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by multiplying the percent from BRFSS and the total number of women 18 to 44 years of age.

STATE PERFORMANCE MEASURE # 5 - REPORTING YEAR

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Indicator	_____	_____	37.1	39.3	39.4
Numerator	_____	_____	1,432,960	1,529,673	1,508,282
Denominator	_____	_____	3,865,559	3,894,222	3,831,601
Data Source			School Physical Activity & Nutrition Survey	School Physical Activity & Nutrition Survey	School Physical Activity & Nutrition Survey
Is the Data Provisional or Final?				Final	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	38	38	37	37	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

1. 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 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).

Denominator data is a 2010 population projection from the Office of the State Demographer.

2. Section Number: Form11_State Performance Measure #5

Field Name: SM5

Row Name:

Column Name:

Year: 2009

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 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).

Denominator data is from the Office of the State Demographer.

3. Section Number: Form11_State Performance Measure #5

Field Name: SM5

Row Name:

Column Name:

Year: 2008

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 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).

Denominator data is from the Office of the State Demographer.

STATE PERFORMANCE MEASURE # 6 - REPORTING YEAR

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Indicator	_____	_____	14.1	14.5	14.7
Numerator	_____	_____	917	954	907
Denominator	_____	_____	6,495,224	6,557,436	6,179,238
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
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	14	14	13.8	13.8	13.6
Annual Indicator					
Numerator					
Denominator					

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.

Field Level Notes

- Section Number:** Form11_State Performance Measure #6

Field Name: SM6

Row Name:

Column Name:

Year: 2010

Field Note:

Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 2005 through 2008.

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: 2009

Field Note:

Mortality data reported for 2009 is provisional.

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

- Section Number:** Form11_State Performance Measure #6

Field Name: SM6

Row Name:

Column Name:

Year: 2008

Field Note:

Mortality data reported for 2008 is final.

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

STATE PERFORMANCE MEASURE # 7 - REPORTING YEAR

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

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
Data Source					
Is the Data Provisional or Final?					

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	_____	_____	_____	_____	_____
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: 2010

Field Note:

The MCH survey assessing program utilization of research findings and/or evidence-based practices for program improvement and development has yet to be conducted. The survey is currently being administered. The results of the survey will be available and ready for dissemination by September 1, 2011.

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

Natality and mortality data in Texas is final for 2008 and provisional for 2009. All data reported for 2010 is estimated. Bridged race algorithms have not been applied to provisional data; therefore, race specific data for 2009 is estimated. Estimates are linear projections based on data from 1995 through 2008 (unless otherwise noted in a field level note). Population estimates through 2009 and 2010 projections are provided by the Texas Office of the State Demographer (TxSDC). A summary of these data can be found on the Texas DSHS website (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>). Projections of the 2010 population are produced by TxSDC using a model of projected births and deaths, rather than actual records. Both estimation and projection models use estimates of migration rates produced by the TxSDC. The Texas Health and Human Services Commission (HHSC) has designated the "2000 - 2007 Scenario" to be the current standard for HHSC agency population projections. The 2000-2007 projection scenario provides a scenario that takes into account post-2000 population trends. (http://txsdc.utsa.edu/tpepp/2008projections/2008_Texas_County_Projection_Methodology.pdf) Current population estimates developed through 2009 using actual records (births, deaths, school enrollment, voter registration, etc) have revealed that population projections using the 2000-2007 scenario may be an underestimate. As a result, indicators using 2010 population projections as a denominator are likely to be overestimated. Annual performance objectives from 2011 through 2015 have been adjusted for changing trends where necessary.

OUTCOME MEASURE # 01

The infant mortality rate per 1,000 live births.

	Annual Objective and Performance Data				
	2006	2007	2008	2009	2010
Annual Performance Objective	5.5	5.5	5.5	6.5	5.5
Annual Indicator	6.5	5.9	6.2	6.1	6.2
Numerator	2,522	2,356	2,530	2,454	2,607
Denominator	390,702	398,319	405,242	401,610	419,318
Data Source			Natality and Mortality Data	Natality and Mortality Data	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.					
<small>(Explain data in a year note. See Guidance, Appendix IX.)</small>					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2011	2012	2013	2014	2015
Annual Performance Objective	6	6	5.9	5.9	5.8
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_Outcome Measure 1

Field Name: OM01

Row Name:

Column Name:

Year: 2010

Field Note:

Natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1995 through 2008.

Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 1995 through 2008.

- Section Number:** Form12_Outcome Measure 1

Field Name: OM01

Row Name:

Column Name:

Year: 2009

Field Note:

Natality and mortality data for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

- Section Number:** Form12_Outcome Measure 1

Field Name: OM01

Row Name:

Column Name:

Year: 2008

Field Note:

Natality and mortality data for 2008 are final. This indicator has been adjusted for final data.

OUTCOME MEASURE # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	<u>1.7</u>	<u>1.7</u>	<u>1.7</u>	<u>2.5</u>	<u>2.3</u>
Annual Indicator	<u>2.6</u>	<u>2.5</u>	<u>1.7</u>	<u>2.3</u>	<u>2.3</u>
Numerator	<u>12.5</u>	<u>12.4</u>	<u>10.1</u>	<u>12.5</u>	<u>12.5</u>
Denominator	<u>4.9</u>	<u>4.9</u>	<u>6</u>	<u>5.5</u>	<u>5.5</u>
Data Source			Natality and Mortality Data	Natality and Mortality Data	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.					
<i>(Explain data in a year note. See Guidance, Appendix IX.)</i>					
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	<u>2.2</u>	<u>2.2</u>	<u>2.1</u>	<u>2.1</u>	<u>2</u>
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: 2010

Field Note:

Natality data reported for 2009 and 2010 are estimates. Estimates are linear projections based on data from 1995 through 2008.

Mortality data reported for 2009 and 2010 are estimates. Estimates are linear projections based on data from 1995 through 2008.

2. **Section Number:** Form12_Outcome Measure 2

Field Name: OM02

Row Name:

Column Name:

Year: 2009

Field Note:

Natality data reported for 2009 and 2010 are estimates. Estimates are linear projections based on data from 1995 through 2008.

Mortality data reported for 2009 and 2010 are estimates. Estimates are linear projections based on data from 1995 through 2008.

3. **Section Number:** Form12_Outcome Measure 2

Field Name: OM02

Row Name:

Column Name:

Year: 2008

Field Note:

Natality and mortality data for 2008 are final. This indicator has been adjusted for final data.

OUTCOME MEASURE # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5
Annual Indicator	3.8	3.8	3.9	3.9	4.0
Numerator	1,497	1,530	1,576	1,551	1,673
Denominator	390,702	398,319	405,242	401,610	419,318
Data Source			Natality and Mortality Data	Natality and Mortality Data	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

	2011	2012	2013	2014	2015
Annual Performance Objective	3.8	3.8	3.7	3.7	3.6
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: 2010

Field Note:

Natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1995 through 2008.

Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 1995 through 2008.

2. **Section Number:** Form12_Outcome Measure 3

Field Name: OM03

Row Name:

Column Name:

Year: 2009

Field Note:

Natality and mortality data for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

3. **Section Number:** Form12_Outcome Measure 3

Field Name: OM03

Row Name:

Column Name:

Year: 2008

Field Note:

Natality and mortality data for 2008 are final. This indicator has been adjusted for final data.

OUTCOME MEASURE # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2006	2007	2008	2009	2010
Annual Performance Objective	2.4	2.4	2	1.9	1.9
Annual Indicator	2.1	2.1	2.4	2.2	2.2
Numerator	815	826	954	903	934
Denominator	390,702	398,319	405,242	401,610	419,318
Data Source			Natality and Mortality Data	Natality and Mortality Data	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

	2011	2012	2013	2014	2015
Annual Performance Objective	2.1	2.1	2	2	1.9
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

- Section Number: Form12_Outcome Measure 4

Field Name: OM04

Row Name:

Column Name:

Year: 2010

Field Note:

Natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1995 through 2008.

Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 1995 through 2008.

- Section Number: Form12_Outcome Measure 4

Field Name: OM04

Row Name:

Column Name:

Year: 2009

Field Note:

Natality and mortality data for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

- Section Number: Form12_Outcome Measure 4

Field Name: OM04

Row Name:

Column Name:

Year: 2008

Field Note:

Natality and mortality data for 2008 are final. This indicator has been adjusted for final data.

OUTCOME MEASURE # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

	Annual Objective and Performance Data				
	2006	2007	2008	2009	2010
Annual Performance Objective	8.9	8.9	8.9	5.1	5
Annual Indicator	5.5	5.4	5.6	5.4	5.3
Numerator	2,144	2,205	2,286	2,174	2,218
Denominator	390,541	407,599	406,291	402,597	414,607
Data Source			Natality, Mortality, and Fetal Death Data	Natality, Mortality, and Fetal Death Data	Natality, Mortality, and Fetal Death Data
<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>(Explain data in a year note. See Guidance, Appendix IX.)</p>					
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2011	2012	2013	2014	2015
Annual Performance Objective	5.2	5.2	5.1	5.1	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

- Section Number:** Form12_Outcome Measure 5
Field Name: OM05
Row Name:
Column Name:
Year: 2010
Field Note:
 Natality, mortality, and fetal death data reported for 2010 are estimated. Estimates are linear projections based on data from 2004 through 2008. Fetal death reporting requirements changed in 2004.
- Section Number:** Form12_Outcome Measure 5
Field Name: OM05
Row Name:
Column Name:
Year: 2009
Field Note:
 Natality, mortality, and fetal death data for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.
- Section Number:** Form12_Outcome Measure 5
Field Name: OM05
Row Name:
Column Name:
Year: 2008
Field Note:
 Natality, mortality, and fetal death data for 2008 are final. This indicator has been adjusted for final data.

OUTCOME MEASURE # 06

The child death rate per 100,000 children aged 1 through 14.

	<u>Annual Objective and Performance Data</u>				
	2006	2007	2008	2009	2010
Annual Performance Objective	23.1	23.1	21	19.5	19
Annual Indicator	21.3	20.6	20.7	21.0	19.9
Numerator	1,045	1,028	1,033	1,058	1,017
Denominator	4,898,370	4,989,692	4,987,021	5,049,935	5,117,214
Data Source			Natality Data and Office of the State Demographer	Natality Data and Office of the State Demographer	Natality Data and Office of the State Demographer
<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>(Explain data in a year note. See Guidance, Appendix IX.)</p>					
Is the Data Provisional or Final?				Provisional	Provisional

	<u>Annual Objective and Performance Data</u>				
	2011	2012	2013	2014	2015
Annual Performance Objective	19	19	18.5	18.5	18
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_Outcome Measure 6
Field Name: OM06
Row Name:
Column Name:
Year: 2010
Field Note:
Mortality data reported for 2010 is estimated. Estimates are linear projections based on data from 1995 through 2006.
Denominator data is projected by the Office of the State Demographer.
- Section Number:** Form12_Outcome Measure 6
Field Name: OM06
Row Name:
Column Name:
Year: 2009
Field Note:
Mortality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.
Denominator data provided by the Office of the State Demographer.
- Section Number:** Form12_Outcome Measure 6
Field Name: OM06
Row Name:
Column Name:
Year: 2008
Field Note:
Mortality data reported for 2008 is final. This indicator has been adjusted for final data.
Denominator data provided by the Office of the State Demographer.

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

Natality and mortality data in Texas is final for 2008 and provisional for 2009. All data reported for 2010 is estimated. Bridged race algorithms have not been applied to provisional data; therefore, race specific data for 2009 is estimated. Estimates are linear projections based on data from 1995 through 2008 (unless otherwise noted in a field level note). Population estimates through 2009 and 2010 projections are provided by the Texas Office of the State Demographer (TxSDC). A summary of these data can be found on the Texas DSHS website (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>). Projections of the 2010 population are produced by TxSDC using a model of projected births and deaths, rather than actual records. Both estimation and projection models use estimates of migration rates produced by the TxSDC. The Texas Health and Human Services Commission (HHSC) has designated the "2000 - 2007 Scenario" to be the current standard for HHSC agency population projections. The 2000-2007 projection scenario provides a scenario that takes into account post-2000 population trends. (http://txsdc.utsa.edu/tpepp/2008projections/2008_Texas_County_Projection_Methodology.pdf) Current population estimates developed through 2009 using actual records (births, deaths, school enrollment, voter registration, etc) have revealed that population projections using the 2000-2007 scenario may be an underestimate. As a result, indicators using 2010 population projections as a denominator are likely to be overestimated. Annual performance objectives from 2011 through 2015 have been adjusted for changing trends where necessary.

STATE OUTCOME MEASURE # 1 - REPORTING YEAR

The ratio of the Black perinatal mortality rate to the White perinatal mortality rate.

	Annual Objective and Performance Data				
	2006	2007	2008	2009	2010
Annual Performance Objective	<u>1</u>	<u>1</u>	<u>1</u>	<u>3</u>	<u>3</u>
Annual Indicator	<u>3.0</u>	<u>2.5</u>	<u>2.0</u>	<u>2.3</u>	<u>2.3</u>
Numerator	<u>12</u>	<u>10</u>	<u>10</u>	<u>9</u>	<u>9</u>
Denominator	<u>4</u>	<u>4</u>	<u>5</u>	<u>4</u>	<u>4</u>
Data Source			Natality, Mortality, and Fetal Death Data	Natality, Mortality, and Fetal Death Data	Natality, Mortality, and Fetal Death Data
Is the Data Provisional or Final?				Provisional	Provisional

	Annual Objective and Performance Data				
	2011	2012	2013	2014	2015
Annual Performance Objective	<u>2</u>	<u>2</u>	<u>2</u>	<u>1.9</u>	<u>1.9</u>
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: 2010
Field Note:
 Natality, mortality, and fetal death data reported for 2010 are estimated. Estimates are linear projections based on data from 2004 through 2008. Fetal death reporting requirements changed in 2004.
- Section Number:** Form12_State Outcome Measure 1
Field Name: SO1
Row Name:
Column Name:
Year: 2009
Field Note:
 Natality, mortality, and fetal death data reported for 2009 are estimated. Estimates are linear projections based on data from 2004 through 2008. Fetal death reporting requirements changed in 2004.
- Section Number:** Form12_State Outcome Measure 1
Field Name: SO1
Row Name:
Column Name:
Year: 2008
Field Note:
 Natality, mortality, and fetal death data reported for 2008 are final. This indicator has been adjusted for final data.

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

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

 2

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

 3

4. Family members are involved in service training of CSHCN staff and providers.

 2

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).

 2

6. Family members of diverse cultures are involved in all of the above activities.

 3

Total Score: 14

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: 2012
Field Note:
Texas Parent to Parent has expanded 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: 2012
Field Note:
The CSHCN SP supports the parent case management model through funding for community-based organizations provding this model of service delivery in three different areas of Texas.

3. **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: 2012
Field Note:
The CSHCN SP includes several staff members who share their expertise as family members of individuals with special health care needs or disabilities.

FORM 14
LIST OF MCH PRIORITY NEEDS

[Sec. 505(a)(5)]

STATE: TX FY: 2012

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: 2012

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: <u> N/A </u>	Suggestions regarding ongoing efforts to integrate physical, mental, and behavioral health systems for MCH populations.	The topic remains a priority within DSHS. Additionally, 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: <u> N/A </u>	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: <u> N/A </u>	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.	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: <u> </u>			
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: <u> </u>			
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: <u> </u>			
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: <u> </u>			
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: <u> </u>			
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: <u> </u>			
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: _____			
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: _____			
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: _____			

FORM NOTES FOR FORM 15

None

FIELD LEVEL NOTES

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: TX

SP() # 1

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 2010 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() # 2

PERFORMANCE MEASURE:

Rate of excess feto-infant mortality in Texas.

STATUS:

Active

GOAL

To improve perinatal health and reduce modifiable infant morbidity and mortality in Texas.

DEFINITION

Calculate differences in excess feto-infant 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 2010 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 feto-infant 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 feto-infant 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.

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 **Text:** Percent

HEALTHY PEOPLE 2010 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() # 4

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 2010 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() # 5

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 2010 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() # 6

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 2010 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() # 7

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 **Text:** Percent

HEALTHY PEOPLE 2010 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.

SO() # 1

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 2010 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

None

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.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>28.4</u>	<u>27.7</u>	<u>24.1</u>	<u>25.6</u>	<u>28.8</u>
Numerator	<u>5,349</u>	<u>5,284</u>	<u>4,642</u>	<u>4,986</u>	<u>4,549</u>
Denominator	<u>1,881,855</u>	<u>1,906,500</u>	<u>1,927,981</u>	<u>1,951,170</u>	<u>1,581,862</u>

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:** Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2010

Field Note:

Data Source: Texas Hospital Inpatient Discharge Public Use Data File.

The numerator estimates for 2010 are based on a linear projection using data from 2000 through 2009. The data is based on hospitalizations. Therefore, one person may account for multiple hospitalizations. The reported data may underestimate the true rate of hospitalization for asthma because Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the Texas Health Care Information Council (THCIC).

Denominator data are projected by the Office of the State Demographer (TxSDC). Projections of the 2010 population are produced by TxSDC using a model of projected births and deaths, rather than actual records. Both estimation and projection models use estimates of migration rates produced by the TxSDC. The Texas Health and Human Services Commission (HHSC) has designated the "2000 - 2007 Scenario" to be the current standard for HHSC agency population projections. The 2000-2007 projection scenario provides a scenario that takes into account post-2000 population trends.

(http://txsdc.utsa.edu/tpepp/2008projections/2008_Texas_County_Projection_Methodology.pdf) Current population estimates developed through 2009 using actual records (births, deaths, school enrollment, voter registration, etc) have revealed that population projections using the 2000-2007 scenario may be an underestimate. As a result, indicators using 2010 population projections as a denominator are likely to be overestimated.

2. **Section Number:** Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2009

Field Note:

Data Source: Texas Hospital Inpatient Discharge Public Use Data File.

This indicator has been adjusted for final data.

The data is 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.

3. **Section Number:** Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2008

Field Note:

Data Source: Texas Hospital Inpatient Discharge Public Use Data File.

The data is 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.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	100.0	100.0	81.8	81.3	92.9
Numerator	258,808	259,222	197,019	194,131	158,750
Denominator	258,808	259,222	240,911	238,927	170,927

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

- 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.

- Section Number:** Form17_Health Systems Capacity Indicator #02
Field Name: HSC02
Row Name:
Column Name:
Year: 2009
Field Note:
 CMS-416 FFY2009

Incorrect numerator data was reported in Block Grant Applications prior to FY12. Data from 2008-2009 have been corrected.

- Section Number:** Form17_Health Systems Capacity Indicator #02
Field Name: HSC02
Row Name:
Column Name:
Year: 2008
Field Note:
 Texas CMS-416 FFY 2007 - 2008

Incorrect numerator data was reported in Block Grant Applications prior to FY12. Data from 2008-2009 have been corrected.

Prior to 2008, Medicaid service data could not be unduplicated due to the design of the data collection system. As a result, numerator data in 2006 and 2007 exceeded the denominator.

Corrected annual indicators for 2006-2007:
 2006 = 261,999 (Numerator)/258,808 (Denominator) = 101.2%
 2007 = 259,222 (Numerator)/254,196(Denominator) = 102.0%

HEALTH SYSTEMS CAPACITY #03

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>38.5</u>	<u>42.1</u>	<u>70.6</u>	<u>71.7</u>	<u>75.7</u>
Numerator	<u>1,243</u>	<u>944</u>	<u>45,208</u>	<u>64,065</u>	<u>68,729</u>
Denominator	<u>3,226</u>	<u>2,243</u>	<u>64,026</u>	<u>89,369</u>	<u>90,795</u>

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

- 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).
- Section Number:** Form17_Health Systems Capacity Indicator #03
Field Name: HSC03
Row Name:
Column Name:
Year: 2009
Field Note:
 Source: Texas Health and Human Services Commission (HHSC).
- Section Number:** Form17_Health Systems Capacity Indicator #03
Field Name: HSC03
Row Name:
Column Name:
Year: 2008
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.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>62.0</u>	<u>64.0</u>	<u>59.4</u>	<u>60.4</u>	<u>58.0</u>
Numerator	<u>242,388</u>	<u>258,337</u>	<u>240,687</u>	<u>242,458</u>	<u>243,034</u>
Denominator	<u>390,702</u>	<u>403,690</u>	<u>405,242</u>	<u>401,610</u>	<u>419,224</u>

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

- Section Number:** Form17_Health Systems Capacity Indicator #04

Field Name: HSC04

Row Name:

Column Name:

Year: 2010

Field Note:

All natality data reported for 2010 is estimated. 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.

- Section Number:** Form17_Health Systems Capacity Indicator #04

Field Name: HSC04

Row Name:

Column Name:

Year: 2009

Field Note:

All natality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

- Section Number:** Form17_Health Systems Capacity Indicator #04

Field Name: HSC04

Row Name:

Column Name:

Year: 2008

Field Note:

All natality data reported for 2008 is final. This indicator has been adjusted for final data.

HEALTH SYSTEMS CAPACITY #07A

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>64.5</u>	<u>65.6</u>	<u>60.0</u>	<u>64.5</u>	<u>67.5</u>
Numerator	<u>1,370,299</u>	<u>1,405,344</u>	<u>1,311,475</u>	<u>1,484,899</u>	<u>1,749,012</u>
Denominator	<u>2,123,317</u>	<u>2,142,033</u>	<u>2,186,066</u>	<u>2,303,703</u>	<u>2,589,575</u>

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

- 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.

- Section Number:** Form17_Health Systems Capacity Indicator #07A
Field Name: HSC07A
Row Name:
Column Name:
Year: 2009
Field Note:
 Source: Texas CMS-416 FFY 2009.
- Section Number:** Form17_Health Systems Capacity Indicator #07A
Field Name: HSC07A
Row Name:
Column Name:
Year: 2008
Field Note:
 Source: Texas CMS-416 FFY 2008.

HEALTH SYSTEMS CAPACITY #07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>55.2</u>	<u>58.1</u>	<u>61.0</u>	<u>66.0</u>	<u>74.1</u>
Numerator	<u>308,987</u>	<u>330,435</u>	<u>357,067</u>	<u>415,490</u>	<u>483,967</u>
Denominator	<u>559,406</u>	<u>569,106</u>	<u>585,453</u>	<u>629,784</u>	<u>652,987</u>

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

- 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.

- Section Number:** Form17_Health Systems Capacity Indicator #07B
Field Name: HSC07B
Row Name:
Column Name:
Year: 2009
Field Note:
 Source: Texas CMS-416 FFY 2009.

The incorrect numerator was entered for 2009 in the previous application. This number has been corrected.

- Section Number:** Form17_Health Systems Capacity Indicator #07B
Field Name: HSC07B
Row Name:
Column Name:
Year: 2008
Field Note:
 Source: Texas CMS-416 FFY 2007 - 2008.

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.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	25.1	23.0	22.0	22.4	30.6
Numerator	21,088	21,145	21,652	23,493	34,668
Denominator	83,891	91,874	98,409	104,971	113,432

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

- 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.

- Section Number:** Form17_Health Systems Capacity Indicator #08

Field Name: HSC08

Row Name:

Column Name:

Year: 2009

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.

- Section Number:** Form17_Health Systems Capacity Indicator #08

Field Name: HSC08

Row Name:

Column Name:

Year: 2008

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>	2008	Payment source from birth certificate	<u>9.2</u>	<u>7.8</u>	<u>8.4</u>
b) <i>Infant deaths per 1,000 live births</i>	2008	Payment source from birth certificate	<u>6.1</u>	<u>5</u>	<u>5.4</u>
c) <i>Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester</i>	2008	Payment source from birth certificate	<u>48.5</u>	<u>65.8</u>	<u>57.9</u>
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>	2008	Payment source from birth certificate	<u>53.5</u>	<u>64.4</u>	<u>59.4</u>

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>	2010	<u>185</u>
b) <i>Medicaid Children</i> (Age range <u>1</u> to <u>5</u>) (Age range <u>6</u> to <u>18</u>) (Age range <u> </u> to <u> </u>)	2010	<u>133</u> <u>100</u> <u> </u>
c) <i>Pregnant Women</i>	2010	<u>185</u>

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>	2010	<u>200</u>
b) <i>Medicaid Children</i> (Age range <u>1</u> to <u>18</u>) (Age range _____ to _____) (Age range _____ to _____)	2010	<u>200</u> _____ _____
c) <i>Pregnant Women</i>	2010	<u>200</u>

FORM NOTES FOR FORM 18

None

FIELD LEVEL NOTES

1. **Section Number:** Form18_Indicator 05
Field Name: LowBirthWeight
Row Name: Percent of ow birth weight (<2,500 grams)
Column Name:
Year: 2012
Field Note:
Source: 2008 Final Natality File
2. **Section Number:** Form18_Indicator 05
Field Name: InfantDeath
Row Name: Infant deaths per 1,000 live births
Column Name:
Year: 2012
Field Note:
Infant mortality reported here differs from the infant mortality rate reported for 2008 from Form 12, Outcome Measure 1. This occurs because only infants deaths for which a matching birth certificate can be identified are included in the numerator.

Source: Matched Final 2008 Natality File and 2008 Mortality File.
3. **Section Number:** Form18_Indicator 05
Field Name: CareFirstTrimester
Row Name: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
Column Name:
Year: 2012
Field Note:
In 2005, Texas implemented the US Certificate of Live Birth, 2003. This change had a significant impact on measures of prenatal care utilization.

Source: 2008 Final Natality File
4. **Section Number:** Form18_Indicator 05
Field Name: AdequateCare
Row Name: Percent of pregnant women with adequate prenatal care
Column Name:
Year: 2012
Field Note:
In 2005, Texas implemented the US Certificate of Live Birth, 2003. This change had a significant impact on measures of prenatal care utilization.

Source: 2008 Final Natality File

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	2	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: Behavioral Risk Factor Surveillance System (BRFSS)	3	Yes
Pregnancy Risk Assessment Monitoring System (PRAMS)	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

Natality data in Texas are final for 2008 and provisional for 2009. All data reported for 2010 are estimates. Numerator estimates are linear projections based on data from 1996 through 2008 (unless otherwise noted in a field level note). Denominator estimates are linear projections based on data from 1996 through 2008 (unless otherwise noted in a field level note). Mortality data in Texas is final for 2008 and provisional for 2009. All data reported for 2010 are estimates. Estimates are linear projections based on data from 1999 through 2008 (unless otherwise noted in a field level note). Population estimates through 2009 and 2010 projections are provided by the Texas Office of the State Demographer (TxSDC). A summary of these data can be found on the Texas DSHS website (<http://www.dshs.state.tx.us/chs/popdat/detailX.shtm>). Projections of the 2010 population are produced by TxSDC using a model of projected births and deaths, rather than actual records. Both estimation and projection models use estimates of migration rates produced by the TxSDC. The Texas Health and Human Services Commission (HHSC) has designated the "2000 - 2007 Scenario" to be the current standard for HHSC agency population projections. The 2000-2007 projection scenario provides a scenario that takes into account post-2000 population trends. (http://txsdc.utsa.edu/tpepp/2008projections/2008_Texas_County_Projection_Methodology.pdf) Current population estimates developed through 2009 using actual records (births, deaths, school enrollment, voter registration, etc) have revealed that population projections using the 2000-2007 scenario may be an underestimate. As a result, indicators using 2010 population projections as a denominator are likely to be overestimated.

HEALTH STATUS INDICATOR #01A

The percent of live births weighing less than 2,500 grams.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	8.3	8.5	8.4	8.5	8.6
Numerator	32,453	33,834	34,230	34,137	36,218
Denominator	390,702	398,319	405,244	401,610	418,873

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

- Section Number:** Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2010

Field Note:

All natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1996 through 2008.

- Section Number:** Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2009

Field Note:

All natality data reported for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

- Section Number:** Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2008

Field Note:

All natality data reported for 2008 are final. This indicator has been adjusted for final data.

HEALTH STATUS INDICATOR #01B

The percent of live singleton births weighing less than 2,500 grams.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>6.5</u>	<u>6.7</u>	<u>6.7</u>	<u>6.7</u>	<u>6.9</u>
Numerator	<u>25,021</u>	<u>26,146</u>	<u>26,458</u>	<u>26,081</u>	<u>27,801</u>
Denominator	<u>383,887</u>	<u>391,349</u>	<u>392,755</u>	<u>388,749</u>	<u>405,495</u>

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

- Section Number:** Form20_Health Status Indicator #01B

Field Name: HSI01B**Row Name:****Column Name:****Year:** 2010**Field Note:**

All natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1996 through 2008.

- Section Number:** Form20_Health Status Indicator #01B

Field Name: HSI01B**Row Name:****Column Name:****Year:** 2009**Field Note:**

All natality data reported for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

- Section Number:** Form20_Health Status Indicator #01B

Field Name: HSI01B**Row Name:****Column Name:****Year:** 2008**Field Note:**

All natality data reported for 2008 are final. This indicator has been adjusted for final data.

HEALTH STATUS INDICATOR #02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>1.5</u>	<u>1.5</u>	<u>1.5</u>	<u>1.5</u>	<u>1.5</u>
Numerator	<u>5,788</u>	<u>6,097</u>	<u>5,924</u>	<u>5,938</u>	<u>6,302</u>
Denominator	<u>390,702</u>	<u>398,319</u>	<u>405,244</u>	<u>401,610</u>	<u>418,873</u>

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

- Section Number:** Form20_Health Status Indicator #02A

Field Name: HSI02A

Row Name:

Column Name:

Year: 2010

Field Note:

All natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1996 through 2008.

- Section Number:** Form20_Health Status Indicator #02A

Field Name: HSI02A

Row Name:

Column Name:

Year: 2009

Field Note:

All natality data reported for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

- Section Number:** Form20_Health Status Indicator #02A

Field Name: HSI02A

Row Name:

Column Name:

Year: 2008

Field Note:

All natality data reported for 2008 are final. This indicator has been adjusted for final data.

HEALTH STATUS INDICATOR #02B

The percent of live singleton births weighing less than 1,500 grams.

	<u>Annual Indicator Data</u>				
	2006	2007	2008	2009	2010
Annual Indicator	1.1	1.1	1.1	1.1	1.1
Numerator	4,207	4,437	4,335	4,387	4,662
Denominator	383,887	391,349	392,755	388,749	405,495

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.)***Is the Data Provisional or Final?**

Provisional

Provisional

Field Level Notes

- Section Number:** Form20_Health Status Indicator #02B

Field Name: HSI02B**Row Name:****Column Name:****Year:** 2010**Field Note:**

All natality data reported for 2010 is estimated. Estimates are linear projections based on data from 1996 through 2008.

- Section Number:** Form20_Health Status Indicator #02B

Field Name: HSI02B**Row Name:****Column Name:****Year:** 2009**Field Note:**

All natality data reported for 2009 are provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

- Section Number:** Form20_Health Status Indicator #02B

Field Name: HSI02B**Row Name:****Column Name:****Year:** 2008**Field Note:**

All natality data reported for 2008 are final. This indicator has been adjusted for final data.

HEALTH STATUS INDICATOR #03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>9.3</u>	<u>9.3</u>	<u>8.7</u>	<u>8.8</u>	<u>9.1</u>
Numerator	<u>491</u>	<u>496</u>	<u>471</u>	<u>478</u>	<u>466</u>
Denominator	<u>5,287,340</u>	<u>5,332,129</u>	<u>5,384,151</u>	<u>5,449,069</u>	<u>5,117,214</u>

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: 2010

Field Note:

All mortality data reported for 2010 is estimated. Estimates are based on a linear trend of data from 1999 through 2008.

Denominator data projected by the Office of the State Demographer.

2. **Section Number:** Form20_Health Status Indicator #03A

Field Name: HSI03A

Row Name:

Column Name:

Year: 2009

Field Note:

All mortality data reported for 2008 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Denominator data provided by the Office of the State Demographer.

3. **Section Number:** Form20_Health Status Indicator #03A

Field Name: HSI03A

Row Name:

Column Name:

Year: 2008

Field Note:

All mortality data reported for 2008 is final. This indicator has been adjusted for final data.

Denominator data provided by 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.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>4.9</u>	<u>4.7</u>	<u>3.5</u>	<u>3.7</u>	<u>3.9</u>
Numerator	<u>259</u>	<u>248</u>	<u>188</u>	<u>200</u>	<u>200</u>
Denominator	<u>5,287,340</u>	<u>5,332,129</u>	<u>5,384,151</u>	<u>5,449,069</u>	<u>5,117,214</u>

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 #03B

Field Name: HSI03B

Row Name:

Column Name:

Year: 2010

Field Note:

All mortality data reported for 2010 is estimated. Estimates are based on a linear trend of data from 1999 through 2008.

Denominator data projected by the Office of the State Demographer.

2. **Section Number:** Form20_Health Status Indicator #03B

Field Name: HSI03B

Row Name:

Column Name:

Year: 2009

Field Note:

All mortality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Denominator data provided by the Office of the State Demographer.

3. **Section Number:** Form20_Health Status Indicator #03B

Field Name: HSI03B

Row Name:

Column Name:

Year: 2008

Field Note:

All mortality data reported for 2008 is final. This indicator has been adjusted for final data.

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.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>27.7</u>	<u>26.0</u>	<u>25.3</u>	<u>22.0</u>	<u>23.5</u>
Numerator	<u>1,000</u>	<u>953</u>	<u>937</u>	<u>825</u>	<u>871</u>
Denominator	<u>3,610,691</u>	<u>3,658,558</u>	<u>3,703,880</u>	<u>3,751,857</u>	<u>3,704,504</u>

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 #03C

Field Name: HSI03C

Row Name:

Column Name:

Year: 2010

Field Note:

All mortality data reported for 2010 is estimated. Estimates are based on a linear trend of data from 1999 through 2008.

Denominator data projected by the Office of the State Demographer.

2. **Section Number:** Form20_Health Status Indicator #03C

Field Name: HSI03C

Row Name:

Column Name:

Year: 2009

Field Note:

All mortality data reported for 2009 is provisional. This indicator has been adjusted for provisional data. In the previous grant application, this indicator was based on a linear trend.

Denominator data provided by the Office of the State Demographer.

3. **Section Number:** Form20_Health Status Indicator #03C

Field Name: HSI03C

Row Name:

Column Name:

Year: 2008

Field Note:

All mortality data reported for 2008 is final. This indicator has been adjusted for final data.

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				
	2006	2007	2008	2009	2010
Annual Indicator	<u>253.1</u>	<u>260.3</u>	<u>279.8</u>	<u>286.1</u>	<u>319.7</u>
Numerator	<u>13,383</u>	<u>13,880</u>	<u>15,067</u>	<u>15,590</u>	<u>16,358</u>
Denominator	<u>5,287,340</u>	<u>5,332,129</u>	<u>5,384,151</u>	<u>5,449,069</u>	<u>5,117,214</u>

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

- Section Number:** Form20_Health Status Indicator #04A

Field Name: HSI04A

Row Name:

Column Name:

Year: 2010

Field Note:

Numerator data for 2010 is a linear projection using the Texas EMS Trauma Registry data from 2004 through 2009. Denominator data is a 2010 population projection from the Office of the State Demographer.

- Section Number:** Form20_Health Status Indicator #04A

Field Name: HSI04A

Row Name:

Column Name:

Year: 2009

Field Note:

Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. The denominator for this indicator has been adjusted for final data. Data from 2006 through 2009 are final.

- Section Number:** Form20_Health Status Indicator #04A

Field Name: HSI04A

Row Name:

Column Name:

Year: 2008

Field Note:

Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. Data from 2006 through 2009 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				
	2006	2007	2008	2009	2010
Annual Indicator	<u>43.8</u>	<u>43.1</u>	<u>42.5</u>	<u>38.7</u>	<u>42.1</u>
Numerator	<u>2,318</u>	<u>2,296</u>	<u>2,286</u>	<u>2,109</u>	<u>2,152</u>
Denominator	<u>5,287,340</u>	<u>5,332,129</u>	<u>5,384,151</u>	<u>5,449,069</u>	<u>5,117,214</u>

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

- Section Number:** Form20_Health Status Indicator #04B
Field Name: HSI04B
Row Name:
Column Name:
Year: 2010
Field Note:
 Numerator data for 2010 is a linear projection using the Texas EMS Trauma Registry data from 2004 through 2009. Denominator data is a 2010 population projection from the Office of the State Demographer.
- Section Number:** Form20_Health Status Indicator #04B
Field Name: HSI04B
Row Name:
Column Name:
Year: 2009
Field Note:
 Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. The denominator for this indicator has been adjusted for final data. Data from 2006 through 2009 are final.
- Section Number:** Form20_Health Status Indicator #04B
Field Name: HSI04B
Row Name:
Column Name:
Year: 2008
Field Note:
 Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. Data from 2006 through 2009 are final.

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				
	2006	2007	2008	2009	2010
Annual Indicator	<u>177.5</u>	<u>173.7</u>	<u>167.8</u>	<u>155.8</u>	<u>166.3</u>
Numerator	<u>6,408</u>	<u>6,356</u>	<u>6,216</u>	<u>5,846</u>	<u>6,159</u>
Denominator	<u>3,610,691</u>	<u>3,658,558</u>	<u>3,703,880</u>	<u>3,751,857</u>	<u>3,704,504</u>

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

- Section Number:** Form20_Health Status Indicator #04C
Field Name: HSI04C
Row Name:
Column Name:
Year: 2010
Field Note:
 Numerator data for 2010 is a linear projection using the Texas EMS Trauma Registry data from 2004 through 2009. Denominator data is a 2010 population projection from the Office of the State Demographer.
- Section Number:** Form20_Health Status Indicator #04C
Field Name: HSI04C
Row Name:
Column Name:
Year: 2009
Field Note:
 Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. The denominator for this indicator has been adjusted for final data. Data from 2006 through 2009 are final.
- Section Number:** Form20_Health Status Indicator #04C
Field Name: HSI04C
Row Name:
Column Name:
Year: 2008
Field Note:
 Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer. Data from 2006 through 2009 are final.

HEALTH STATUS INDICATOR #05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

	Annual Indicator Data				
	2006	2007	2008	2009	2010
Annual Indicator	<u>25.6</u>	<u>27.8</u>	<u>31.8</u>	<u>33.1</u>	<u>37.6</u>
Numerator	<u>22,583</u>	<u>24,946</u>	<u>28,928</u>	<u>30,350</u>	<u>33,296</u>
Denominator	<u>880,975</u>	<u>895,967</u>	<u>908,436</u>	<u>916,799</u>	<u>884,745</u>

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

- 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 projected by the Office of the State Demographer.
- Section Number:** Form20_Health Status Indicator #05A
Field Name: HSI05A
Row Name:
Column Name:
Year: 2009
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. Denominator data has been adjusted for final population estimates.
- Section Number:** Form20_Health Status Indicator #05A
Field Name: HSI05A
Row Name:
Column Name:
Year: 2008
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				
	2006	2007	2008	2009	2010
Annual Indicator	<u>8.5</u>	<u>9.4</u>	<u>10.7</u>	<u>11.0</u>	<u>12.4</u>
Numerator	<u>36,124</u>	<u>40,635</u>	<u>46,526</u>	<u>48,639</u>	<u>56,576</u>
Denominator	<u>4,263,884</u>	<u>4,310,753</u>	<u>4,366,483</u>	<u>4,430,565</u>	<u>4,571,960</u>

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

- 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 projected by the Office of the State Demographer.
- Section Number:** Form20_Health Status Indicator #05B
Field Name: HSI05B
Row Name:
Column Name:
Year: 2009
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. Denominator data has been adjusted for final population estimates.
- Section Number:** Form20_Health Status Indicator #05B
Field Name: HSI05B
Row Name:
Column Name:
Year: 2008
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.

**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: 2010 Is this data from a State Projection? Yes Is this data final or provisional? Provisional

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	405,471	345,043	44,678	0	0	0	0	15,750
Children 1 through 4	1,581,862	1,345,250	175,881	0	0	0	0	60,731
Children 5 through 9	1,862,632	1,580,364	213,816	0	0	0	0	68,452
Children 10 through 14	1,672,720	1,391,614	221,755	0	0	0	0	59,351
Children 15 through 19	1,810,902	1,487,723	252,661	0	0	0	0	70,518
Children 20 through 24	1,893,602	1,562,230	254,251	0	0	0	0	77,121
Children 0 through 24	9,227,189	7,712,224	1,163,042	0	0	0	0	351,923

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	192,277	213,194	0
Children 1 through 4	773,390	808,472	0
Children 5 through 9	974,115	888,517	0
Children 10 through 14	935,915	736,805	0
Children 15 through 19	1,029,080	781,822	0
Children 20 through 24	1,086,324	807,278	0
Children 0 through 24	4,991,101	4,236,088	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: 2008 Is this data from a State Projection? No Is this data final or provisional? Final

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	841	687	146	0	0	0	0	8
Women 15 through 17	18,934	16,246	2,476	0	0	0	0	212
Women 18 through 19	35,315	29,721	5,216	0	0	0	0	378
Women 20 through 34	302,781	255,043	33,735	0	0	0	0	14,003
Women 35 or older	47,366	39,127	4,257	0	0	0	0	3,982
Women of all ages	405,237	340,824	45,830	0	0	0	0	18,583

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	220	621	0
Women 15 through 17	5,763	13,171	0
Women 18 through 19	14,306	21,009	0
Women 20 through 34	154,919	147,862	0
Women 35 or older	27,204	20,162	0
Women of all ages	202,412	202,825	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: 2008 Is this data from a State Projection? No Is this data final or provisional? Final

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	2,530	1,941	461	0	0	0	0	128
Children 1 through 4	521	417	79	0	0	0	0	25
Children 5 through 9	237	194	34	0	0	0	0	9
Children 10 through 14	275	225	36	0	0	0	0	14
Children 15 through 19	1,118	963	117	0	0	0	0	38
Children 20 through 24	1,824	1,548	208	0	0	0	0	68
Children 0 through 24	6,505	5,288	935	0	0	0	0	282

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	1,419	1,111	0
Children 1 through 4	303	218	0
Children 5 through 9	141	96	0
Children 10 through 14	176	99	0
Children 15 through 19	739	379	0
Children 20 through 24	1,251	573	0
Children 0 through 24	4,029	2,476	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	7,333,587	6,149,994	908,791	0	0	0	0	274,802	2010
Percent in household headed by single parent	35.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Number enrolled in Medicaid	2,609,815	2,054,999	417,996	8,261	34,674	0	0	93,885	2010
Number enrolled in SCHIP	522,696	209,646	29,139	921	11,359	0	0	271,631	2010
Number living in foster home care	17,027	11,487	5,174	45	58	0	0	263	2010
Number enrolled in food stamp program	2,041,195	1,557,915	422,105	8,157	26,509	0	0	26,509	2010
Number enrolled in WIC	1,317,590	1,131,316	150,634	757	13,346	1,136	20,383	18	2010
Rate (per 100,000) of juvenile crime arrests	2,397.0	2,123.9	4,847.0	0.0	0.0	0.0	0.0	532.3	2010
Percentage of high school drop-outs (grade 9 through 12)	2.9	1.3	4.4	2.2	1.0	0.0	0.0	0.0	2009

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	3,904,777	3,428,810	0	2010
Percent in household headed by single parent	0.0	0.0	35.0	2009
Percent in TANF (Grant) families	0.0	0.0	1.4	2009
Number enrolled in Medicaid	1,006,869	1,602,946	0	2010
Number enrolled in SCHIP	365,748	156,948	0	2010
Number living in foster home care	10,548	6,479	0	2010
Number enrolled in food stamp program	927,816	1,111,340	0	2010
Number enrolled in WIC	364,712	952,878	0	2010
Rate (per 100,000) of juvenile crime arrests	2,387.3	2,407.9	0.0	2010
Percentage of high school drop-outs (grade 9 through 12)	0.0	3.8	0.0	2009

**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: 2010 Is this data from a State Projection? Yes Is this data final or provisional? Provisional

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	6,482,270
Living in urban areas	6,793,375
Living in rural areas	484,101
Living in frontier areas	56,111
Total - all children 0 through 19	7,333,587

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: 2010 Is this data from a State Projection? Yes Is this data final or provisional? Provisional

POVERTY LEVELS	TOTAL
Total Population	25,373,948.0
Percent Below: 50% of poverty	6.8
100% of poverty	16.6
200% of poverty	37.4

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HEALTH STATUS INDICATORS
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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: 2010 Is this data from a State Projection? Yes Is this data final or provisional? Provisional

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	<u>7,333,587.0</u>
Percent Below: 50% of poverty	<u>10.3</u>
100% of poverty	<u>23.8</u>
200% of poverty	<u>48.0</u>

FORM NOTES FOR FORM 21

None

FIELD LEVEL NOTES

1. **Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2012
Field Note:
Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.
2. **Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2012
Field Note:
Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.
3. **Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2012
Field Note:
Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.
4. **Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2012
Field Note:
Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.
5. **Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2012
Field Note:
Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.
6. **Section Number:** Form21_Indicator 06A
Field Name: S06_Race_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2012
Field Note:
Due to limitations in reporting of the data, the total White population includes all Hispanic people, regardless of race. Information is not available by American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, or more than one race group. Population in these groups are included in Other and Unknown.
7. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women15
Row Name: Women < 15
Column Name:
Year: 2012
Field Note:
Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
8. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women15to17
Row Name: Women 15 through 17
Column Name:
Year: 2012
Field Note:
Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
9. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women18to19
Row Name: Women 18 through 19
Column Name:
Year: 2012
Field Note:
Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
10. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women20to34
Row Name: Women 20 through 34
Column Name:
Year: 2012
Field Note:

Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

11. **Section Number:** Form21_Indicator 07A
Field Name: Race_Women35
Row Name: Women 35 or older
Column Name:
Year: 2012
Field Note:
Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
12. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women15
Row Name: Women < 15
Column Name:
Year: 2012
Field Note:
Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
13. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women15to17
Row Name: Women 15 through 17
Column Name:
Year: 2012
Field Note:
Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
14. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women18to19
Row Name: Women 18 through 19
Column Name:
Year: 2012
Field Note:
Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
15. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women20to34
Row Name: Women 20 through 34
Column Name:
Year: 2012
Field Note:
Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
16. **Section Number:** Form21_Indicator 07B
Field Name: Ethnicity_Women35
Row Name: Women 35 or older
Column Name:
Year: 2012
Field Note:
Source: Final Natality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
17. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
18. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
19. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
20. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
21. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children15to19

- Row Name:** children 15 through 19
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
22. **Section Number:** Form21_Indicator 08A
Field Name: S08_Race_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
23. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Infants
Row Name: Infants 0 to 1
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
24. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children1to4
Row Name: children 1 through 4
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
25. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children5to9
Row Name: children 5 through 9
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
26. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children10to14
Row Name: children 10 through 14
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
27. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children15to19
Row Name: children 15 through 19
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
28. **Section Number:** Form21_Indicator 08B
Field Name: S08_Ethnicity_Children20to24
Row Name: children 20 through 24
Column Name:
Year: 2012
Field Note:
Source: Final Mortality File, 2008. Texas Department of State Health Services, Center for Health Statistics.
29. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_Children
Row Name: All children 0 through 19
Column Name:
Year: 2012
Field Note:
2010 Population Projections provided by the Office of the State Demographer. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.
30. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2012
Field Note:
Source: Annie E. Casey Foundation's KIDS COUNT 2010 Data Book Online (<http://datacenter.kidscount.org/databook/2010/Default.aspx>). Data are from 2009. Data are not available by race/ethnicity.
31. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2012
Field Note:
Source: Annie E. Casey Foundation's Texas Kids Count. <http://datacenter.kidscount.org/DataBook/2010/StateProfiles.aspx>
Data are for 2009 and are based on children 0-17 years of age. Data are not available by race/ethnicity.
32. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_MedicaidNo

Row Name: Number enrolled in Medicaid

Column Name:

Year: 2012

Field Note:

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2010. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages less than 19.

33. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_SCHIPNo

Row Name: Number enrolled in SCHIP

Column Name:

Year: 2012

Field Note:

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2010. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages less than 19.

34. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_FoodStampNo

Row Name: Number enrolled in food stamp program

Column Name:

Year: 2012

Field Note:

Source: Texas Food Stamp Client Profile, Strategic Decision Support, Health and Human Services Commission, Texas, 2010. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages 0-19.

35. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_WICNo

Row Name: Number enrolled in WIC

Column Name:

Year: 2012

Field Note:

These data are reported through certification data provided by the WIC program. Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

36. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_JuvenileCrimeRate

Row Name: Rate (per 100,000) of juvenile crime arrests

Column Name:

Year: 2012

Field Note:

Source: 2010 Juvenile Crime Data report provided by the Texas Department of Public Safety. Maggie Walker, Statistician, Uniform Crime Reporting, maggie.walker@txdps.state.tx.us. Data are reported for children aged 0-17.

Rates for this measure were calculated incorrectly for prior years. Data for 2010 are not comparable to previous years. Due to limitations in the reporting of the data, the total White population (denominator) includes all Hispanic people regardless of race. As a result, the white rate is slightly underestimated and the black rate is slightly overestimated. In 2009, the White denominator was limited to the number of White, Non-Hispanics, leading to an extreme overestimate of the White rate. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

37. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_DropOutPercent

Row Name: Percentage of high school drop-outs (grade 9 through 12)

Column Name:

Year: 2012

Field Note:

Source: Texas Education Agency (http://www.tea.state.tx.us/acctres/dropcomp_index.html, annual dropout rates). Data are from the 2008-2009 academic year.

38. **Section Number:** Form21_Indicator 09B

Field Name: HSIEthnicity_Children

Row Name: All children 0 through 19

Column Name:

Year: 2012

Field Note:

Source: 2010 Population Projections provided by the Office of the State Demographer.

39. **Section Number:** Form21_Indicator 09B

Field Name: HSIEthnicity_SingleParentPercent

Row Name: Percent in household headed by single parent

Column Name:

Year: 2012

Field Note:

Source: Annie E. Casey Foundation's KIDS COUNT 2010 Data Book Online (<http://datacenter.kidscount.org/databook/2010/Default.aspx>). Data are from 2009. Data are not available by race/ethnicity.

40. **Section Number:** Form21_Indicator 09B

Field Name: HSIEthnicity_TANFPercent

Row Name: Percent in TANF (Grant) families

Column Name:

Year: 2012

Field Note:

Source: Annie E. Casey Foundation's KIDS COUNT 2010 Data Book Online (<http://datacenter.kidscount.org/databook/2010/Default.aspx>). Data are from 2009. Data are not available by race/ethnicity.

41. **Section Number:** Form21_Indicator 09B

Field Name: HSIEthnicity_MedicaidNo

Row Name: Number enrolled in Medicaid

Column Name:

Year: 2012

Field Note:

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2010.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages less than 19.

42. Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_SCHIPNo

Row Name: Number enrolled in SCHIP

Column Name:

Year: 2012

Field Note:

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2010.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages less than 19.

43. Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_FoodStampNo

Row Name: Number enrolled in food stamp program

Column Name:

Year: 2012

Field Note:

Source: Texas Food Stamp Client Profile, Strategic Decision Support, Health and Human Services Commission, Texas, 2010.

In 2009, this information was erroneously entered for the entire state population. Current data is correctly entered for ages 0-19.

44. Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_WICNo

Row Name: Number enrolled in WIC

Column Name:

Year: 2012

Field Note:

These data are reported through certification data provided by the WIC program.

45. Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_JuvenileCrimeRate

Row Name: Rate (per 100,000) of juvenile crime arrests

Column Name:

Year: 2012

Field Note:

Source: 2010 Juvenile Crime Data report provided by the Texas Department of Public Safety. Maggie Walker, Statistician, Uniform Crime Reporting, maggie.walker@txdps.state.tx.us. Data are reported for children aged 0-17.

46. Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_DropOutPercent

Row Name: Percentage of high school drop-outs (grade 9 through 12)

Column Name:

Year: 2012

Field Note:

Source: Texas Education Agency (http://www.tea.state.tx.us/acctres/dropcomp_index.html, annual dropout rates). Data are from the 2008-2009 academic year.

47. Section Number: Form21_Indicator 10

Field Name: Metropolitan

Row Name: Living in metropolitan areas

Column Name:

Year: 2012

Field Note:

Source: 2010 Population Projections from the Office of the State Demographer.

48. Section Number: Form21_Indicator 10

Field Name: Urban

Row Name: Living in urban areas

Column Name:

Year: 2012

Field Note:

Source: 2010 Population Projections from the Office of the State Demographer.

49. Section Number: Form21_Indicator 10

Field Name: Rural

Row Name: Living in rural areas

Column Name:

Year: 2012

Field Note:

Source: 2010 Population Projections from the Office of the State Demographer.

50. Section Number: Form21_Indicator 10

Field Name: Frontier

Row Name: Living in frontier areas

Column Name:

Year: 2012

Field Note:

Source: 2010 Population Projections from the Office of the State Demographer.

51. Section Number: Form21_Indicator 11

Field Name: S11_total

Row Name: Total Population

Column Name:

Year: 2012

Field Note:

Total population for 2009 is a projection provided by the Office of the State Demographer.

52. Section Number: Form21_Indicator 11

Field Name: S11_50percent

Row Name: Percent Below: 50% of poverty

Column Name:

Year: 2012

Field Note:

Data Set: 2007-2009 American Community Survey 3-Year Estimates Final Version - 9-2-2011

Survey: American Community Survey

53. **Section Number:** Form21_Indicator 11

Field Name: S11_100percent

Row Name: 100% of poverty

Column Name:

Year: 2012

Field Note:

Data Set: 2007-2009 American Community Survey 3-Year Estimates

Survey: American Community Survey

54. **Section Number:** Form21_Indicator 11

Field Name: S11_200percent

Row Name: 200% of poverty

Column Name:

Year: 2012

Field Note:

Data Set: 2007-2009 American Community Survey 3-Year Estimates

Survey: American Community Survey

55. **Section Number:** Form21_Indicator 12

Field Name: S12_Children

Row Name: Children 0 through 19 years old

Column Name:

Year: 2012

Field Note:

Total population for 2009 is a projection provided by the Office of the State Demographer.

56. **Section Number:** Form21_Indicator 12

Field Name: S12_50percent

Row Name: Percent Below: 50% of poverty

Column Name:

Year: 2012

Field Note:

Data Source: U.S. Census Bureau, 2007-2009 American Community Survey 3-Year Public-Use Microdata Samples

http://factfinder.census.gov/home/en/acs_pums_2009_3yr.html

57. **Section Number:** Form21_Indicator 12

Field Name: S12_100percent

Row Name: 100% of poverty

Column Name:

Year: 2012

Field Note:

Data Source: U.S. Census Bureau, 2007-2009 American Community Survey 3-Year Public-Use Microdata Samples

http://factfinder.census.gov/home/en/acs_pums_2009_3yr.html

58. **Section Number:** Form21_Indicator 12

Field Name: S12_200percent

Row Name: 200% of poverty

Column Name:

Year: 2012

Field Note:

Data Source: U.S. Census Bureau, 2007-2009 American Community Survey 3-Year Public-Use Microdata Samples

http://factfinder.census.gov/home/en/acs_pums_2009_3yr.html

59. **Section Number:** Form21_Indicator 09A

Field Name: HSIRace_FosterCare

Row Name: Number living in foster home care

Column Name:

Year: 2012

Field Note:

Due to limitations in reporting of the data, the total White population includes all Hispanic people regardless of race.

Source: Foster care data provided by the Texas Department of Family and Protective Services. Available from 2010 DFPS Annual Report and Data Book.

http://www.dfps.state.tx.us/About/Data_Books_and_Annual_Reports/2010/default.asp

60. **Section Number:** Form21_Indicator 09B

Field Name: HSIEthnicity_FosterCare

Row Name: Number living in foster home care

Column Name:

Year: 2012

Field Note:

Source: Foster care data provided by the Texas Department of Family and Protective Services. Available from 2010 DFPS Annual Report and Data Book.

http://www.dfps.state.tx.us/About/Data_Books_and_Annual_Reports/2010/default.asp

