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1.4 Overview of the State

The purpose of the Texas Title V program is to address the overall intent of the Maternal and Child Health (MCH) Services Block Grant to improve the health of all mothers and children, including children with special health care needs (CSHCN). The state of Texas has responsibility for: a) providing and assuring access to quality MCH services for mothers and children; b) providing and promoting family-centered, community-based, coordinated care for CSHCN; and c) facilitating the development of community-based systems of services for the MCH and CSHCN populations.

As part of the Texas Department of Health (TDH), the Title V program is committed to the four TDH Board of Health strategic directions:

- community-based solutions: a community orientation that creates a synergistic dynamic between the department and local organizations and individuals.
- emphasis on prevention: a prevention strategy that can actually reduce major threats to the health status of our populations.
- focus on outcomes: a moral determination to effect concrete outcomes in the health status of individuals throughout the state.
- TDH as a state leader: a leadership that transcends management.

The Title V program is also committed to addressing state health priorities selected by the Governor as benchmarks for the state strategic plan. Many of these areas are consistent with MCH Bureau national performance measures. The health benchmark areas are to reduce:

- incidence of vaccine-preventable disease
- infant mortality rate
- teen pregnancy rate
- percent of adult Texans dependent on Medicaid
- incidence of confirmed cases of unsafe facilities, or abuse, neglect or death of children, the elderly, persons with disabilities or their spouses.

Texas has several priority areas related to maternal and child health. Some of these priorities are long-term issues, while others relate to state health policy development enacted in 1999 through the 76th Texas Legislature.

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

Texas has roughly 1.4 million uninsured children, one of the highest percentages of uninsured children in the U.S. For children ages 0 through 19 years in all income groups, 23.3% in Texas are uninsured. Based on the Current Population Survey (CPS) data, estimates of the number of uninsured Texas children under the age of

19 for 1995, by age category, are as follows:

Age	# of Children	% Uninsured	# Uninsured
0-5	1,940,458	19.4%	375,695
6-14	2,623,410	23.7%	622,381
15-18	1,120,079	29.4%	328,931
0-18	5,683,947	23.3%	1,327,007

Source: State Children's Health Insurance Program.

With passage of Title XXI, Texas could receive an average of \$400 million per year in federal funds for ten years to expand health insurance to uninsured children. TDH has made Title XXI planning and implementation a high priority. TDH has participated in an interagency workgroup convened by the Texas Health and Human Services Commission (HHSC), the Title XXI lead agency, since the creation of the program. On June 15, 1998, HHSC received federal approval of the Texas Title XXI plan to expand Medicaid eligibility to children ages 15 to age 19 at or below 100% FPL. With this CHIP Phase I approval, the Texas Medicaid program covers children from birth to one year of age up to 185% FPL, ages 1-5 years up to 133% FPL, and ages 6 to 19 years up to 100% FPL.

During 1998-99, the interagency workgroup continued planning activities around developing a second CHIP proposal. TDH participated in conducting public hearings and parent focus group meetings with HHSC to obtain public input for the second phase. In addition, effective October 1, 1998, TDH created a Bureau of CHIP in the Associateship for Health Care Financing and appointed Randy Fritz as Bureau Chief. The new bureau is responsible for coordinating TDH efforts in planning and implementing CHIP with other Texas entities including the HHSC, the Texas Healthy Kids Corporation, and the Texas Legislature.

Phase II of the Texas response (referred to later in this document as "CHIP") is a state-designed program targeting children up to 200 percent FPL who are not otherwise eligible for Medicaid. Within the context of the Phase II program, Texas will also cover legal immigrant children who are ineligible for CHIP under federal law because of their immigration status. Because these children are not eligible for the federal CHIP match, their coverage will be financed solely with state revenue. Under CHIP Phase II, some type of cost-sharing requirement will apply to most eligible families, including annual enrollment fees and co-pays for families below 150 percent FPL, and monthly premiums and co-pays for families above 150 percent FPL. CHIP eligibility will be continuous for a 12-month period. Eligibility for CHIP coverage will be based on income, family size, insurance status, citizenship

status, and residency in Texas, with no assets test. Continuous enrollment will be available during CHIP's first year of operation, and thereafter, specific open-enrollment periods may be used.

To publicize the availability of health insurance to uninsured children, the state will conduct an aggressive and multi-faceted multi-million dollar outreach campaign over a two-year period. The outreach effort will include a statewide advertising campaign that promotes a generic message targeted to all families with uninsured children. A key element of this campaign will be publicizing a toll-free number that parents and others can call to apply for CHIP or obtain additional information. Coalitions of community-based organizations, state agency staff, and other entities will be encouraged to participate in the outreach effort. Cultural competency will be emphasized in all outreach efforts.

Under the leadership of HHSC, Texas has published a Request for proposals (RFP) to procure a comprehensive set of administrative services for CHIP. The selected administrative contractor will design and develop a comprehensive automated record-keeping system in a client server environment. The system will provide an efficient mechanism to process applications for uninsured children appropriately and enroll those who meet federal and state CHIP eligibility guidelines.

On July 19, 1999 Texas will announce its intent to obtain proposals from qualified health Maintenance Organizations (HMOs) to provide comprehensive HMO services (Appendix A) for Texas children determined eligible for CHIP (as authorized by Title XXI of the Social Act and Senate Bill 445, 76th Texas Legislature). While CHIP will be implemented on a statewide basis, this RFP applies only to the counties included in the eight major Texas metropolitan areas identified in Appendix B. Each contracting HMO must start implementing its health coverage by May 1, 2000. Health insurance coverage for CHIP-eligible children residing in the counties located outside the eight CHIP Service Areas will be addressed by a separate RFP.

The 76th Texas Legislature has stipulated that CHIP has first claim on Tobacco Fund dollars. State matching funds, totaling \$179.6 million (\$35.8 million in FY 00 and \$143.8 million in FY 01), were appropriated from the tobacco settlement for the Title XXI CHIP plan. Senate Bill 445 key provisions are as follows:

1. HHSC is the agency charged with implementing CHIP, with the authority to delegate various aspects of the implementation. However, its policy-making role cannot be delegated.
2. The total amount allocated for administrative and outreach costs must fit within the ten percent cap, although there is some flexibility in the first two years regarding how this requirement is intended to be met.
3. HHSC is authorized to direct TDH to implement contracts with health plans and to monitor quality, with specific mention of outcome measurements.
4. The question of whether or how to use the Texas Healthy Kids Corporation (THKC) to implement some or all of CHIP was addressed by giving HHSC the authority to contract with THKC to administer any part of CHIP, subject to THKC passing a

"readiness review."

5. HHSC is directed to do all health plan and administrative services procurement on a competitive basis in compliance with state and federal law.
6. An outreach campaign is required to promote enrollment in CHIP and Medicaid and, subject to THKC board approval, THKC. This outreach effort is consistent with the intent to develop and implement a generic "insure your kids" campaign that is not specifically geared to CHIP-eligible kids but rather to all uninsured children.
7. Regional advisory committees (RACs) are required and HHSC is authorized to take advantage of existing RAC structures to avoid duplication of administrative activities.
8. Income eligibility is set at 200 percent FPL with a statutory mandate for 12 months of continuous coverage.
9. A joint application form and procedure for Medicaid, CHIP, and THKC is mandated. This mandate is also consistent with current program planning.
10. The benefits package benchmark is specifically noted (the NylCare package offered to state employees). The actual benefits in the benefit package must include, at a minimum, those described in the interim CHIP reports.
11. To discourage crowd-out, the bill stipulates a 90-day waiting period (meaning CHIP-eligible children must be uninsured for at least 90 days). However, there are numerous exceptions to this waiting period, including involuntary termination of insurance, loss of Medicaid benefits, and families that drop their insurance because coverage costs more than 10 percent of their net family income.
12. In selecting health plans, HHSC may give preference to THKC or Medicaid HMOs.
13. The bill also creates a CHIP look-alike program (financed with pure GR) for legal immigrant children who are not eligible under the federal statute for CHIP or Medicaid.
14. A separate Senate bill (SB 1351 of the 76th Texas Legislature) authorizes an enhanced Employee Retirement System subsidy for children of state employees who would otherwise qualify for CHIP (state employees are ineligible for CHIP).

Tobacco Settlement

A related major development is that Texas negotiated a \$17.3 billion tobacco lawsuit settlement agreement that includes a variety of health and child health initiatives, including state match for Title XXI. Counties, cities, and hospital districts will receive \$2.3 billion in the settlement. In January 1999 the State Comptroller made the first distribution (\$300 million) from these funds. This money is intended to help cities, counties and hospital districts recoup some of the costs of providing health care to indigent patients with tobacco-related illnesses. The distributions will occur annually using the earnings from a permanent trust fund established through the tobacco settlement.

The first payment to cities, counties and hospital districts was based on the population of each eligible entity, but beginning in 2000 the payments will be based

on unreimbursed health care expenditures as defined in the settlement. TDH is responsible for processing expenditure statements submitted by the local entities and certifying to the State Comptroller the pro rata share that each entity will receive from the annual statewide distribution.

The 76th Texas Legislature created several permanent endowments from tobacco settlement funds related to health that could affect Title V populations. Earnings from these endowments will be used to fund specific activities by the Texas Department of Health (TDH) over the FY 2000-2001 biennium.

- Permanent Fund for Tobacco Education and Enforcement - The fund was endowed for \$200 million. Earnings from this fund will be used for programs to reduce tobacco use in the state, including enhancing existing programs with prevention education initiatives geared toward youth. Estimated earnings appropriated for the biennium were \$10 million per fiscal year. A workgroup has been established and includes representation from several state agencies to determine the best use of these funds by identifying opportunities to incorporate tobacco prevention initiatives into existing programs. Title V School Health program staff have been meeting with representatives from the Workgroup to allocate a portion of the tobacco fund to establish new positions at the 20 Education Service Centers. This is a positive move since the centers are familiar with and experienced in implementing tobacco prevention initiatives.
- Permanent Fund for Children and Public Health - The fund is endowed for \$100 million. Earnings will be used to 1) develop cost-effective prevention and intervention strategies for improving health outcomes for children and the public and 2) provide grants to local communities to address specific health priorities. Estimated earnings appropriated were \$5 million per fiscal year, or \$10 million for the biennium.
- Other permanent funds include Permanent Fund for Emergency Medical Services and Trauma, the Permanent Fund for Rural Health Facility Capital Improvement, and the Community Hospital Capital Improvement Fund.

In addition to creating permanent endowments, tobacco settlement funds were directly appropriated to children's health programs as follows:

- \$9 million (\$4.7 million in FY 2000 and \$4.3 million in FY 2001) was appropriated to reduce the waiting list for children in the Medically Dependent Children Program, a 1915(c) Medicaid waiver program.
- \$2.8 million (\$1.7 million in FY 2000 and \$1.1 million in FY 2001) was appropriated to establish newborn hearing screening program.
- \$179.6 million (\$35.8 million in FY 2000 and \$143.8 million in FY 2001) was appropriated to provide state matching funds for the Title XXI CHIP plan.

Medicaid Managed Care

Texas continues to roll out Medicaid managed care. As of April 1, 1999 there were a total of 418,059 participants in managed care. Of those, 65.8% were in health care maintenance organizations (HMOs) and 34.2% were in the primary care case management (PCCM) model. Texas currently provides services under the Medicaid

managed care program in the following service areas:

- Travis (Travis, Burnet, Blanco, Hays, Caldwell, Bastrop, Lee, Williamson, and Fayette counties),
- Bexar (Bexar, Kendall, Comal, Medina, Atascosa, Wilson, and Guadalupe counties),
- Tarrant (Tarrant, Wise, Denton, Parker, Hood, and Johnson counties),
- Lubbock (Lubbock, Lamb, Hale, Floyd, Crosby, Garza, Lynn, Terry, and Hockley counties),
- Harris (Harris, Fort Bend, Montgomery, Waller, Brazoria, and Galveston counties), and
- Southeast Region (Chambers, Jefferson, Liberty, Hardin, and Orange counties).
- Dallas service area

El Paso service area is expected to roll out by the end of the year. Although Hill Country and Bell/McLennan service areas are scheduled to roll out in the year 2000, HB 2896 (passed by the 76th Texas Legislature) imposes a moratorium on further implementation of Medicaid managed care pilot projects after El Paso service area and until the next legislative session.

Sunset Review Process

Texas has a twelve year cycle for its sunset review process to determine if an agency's functions are still needed, and to determine if changes are needed. From 1997-99 TDH underwent the sunset review process, which included an agency self-evaluation and a Sunset Advisory Commission analysis report with recommendations. The process culminates with the introduction and passage of legislation to continue or sunset (discontinue) the agency. The Texas Legislature passed HB 2085 continuing TDH. A key requirement of HB 2085 affecting Title V is integration of the following elements of all maternal and child health programs, WIC, primary health care, and Medicaid including:

- policy development
- service delivery
- contract administration (including integration of procurement process; uniform contract terms; one-stop information requirement for providers; contract monitoring)
- reimbursement methods

Goals of integration are to:

- ensure medical homes for clients
- reduce administrative and paperwork burdens on providers
- investigate potential for integrating all/ or part of delivery system into a managed

care system with one or more managed care providers; and conduct a pilot project to integrate Medicaid and non-Medicaid services.

Currently, a team within the Associateship for Community Health and Resources Development (CHRD) is developing a service delivery integration action plan with agency-wide implications to respond to HB 2085 requirements and time lines. The scope of this action plan addresses actual community priorities, promotes seamless clinical services for the clients in a medical homes, and administers efficient and cost-effective service delivery for both contractors and TDH programs.

Prior to the passage of this bill, Title V leadership was exploring ways to streamline the current service delivery and, as a result, implemented some initiatives that are in line with these bill provisions. For the past years, staff from CHRD have been working to consolidate the RFP process that required contractors of multiple service programs to duplicate efforts while completing separate RFPs for each of the categorical funding sources. CHRD staff realized that the various programs of the Associateship did not utilize standard terminology, common standards, uniform or integrated eligibility requirements, common reporting and billing systems, or a uniform reimbursement methodology. After a series of meetings with appropriate programs staff, the Associateship implemented an RFP process in FY 99 that combined the applications for Title V (maternal and child health and family planning) and Title X and XX (family planning). In FY 01, the Primary Health Care Program of the Associateship for Community Dynamics and Prevention Strategies will be added to the combined RFP.

Grants for Essential Public Health Services (HB 1444)

This bill came at an opportune time for TDH, since it encourages us to broaden our playing field beyond the traditional medical treatment model and to implement the four strategic principles established for TDH last fall by the Board of Health (i.e., community-based solutions, emphasis on prevention, focus on outcomes, and TDH as a state leader). HB 1444 will help TDH to address the root causes of non-traditional threats to the public's health, including: teen pregnancy, drug and alcohol abuse, sexually transmitted diseases, gang violence, homelessness, and a myriad of other social pathologies. This funding to local communities not only creates a

synergy between TDH programs and communities, but also guides and shapes TDH leadership decision-making in the future as TDH and community health leaders begin to address local needs and seek to alleviate these fundamental causes.

Below is a summary of the bill's background and provisions, and a preliminary plan for implementation. In 1997, the Texas Legislature passed House Concurrent Resolution (HCR) 44, which created a workgroup "to study the current role of local governments in providing public health services." The workgroup was charged with generating a report on problems with the current public health system in Texas and

offering recommendations for statutory and funding changes. The HCR 44 report was published in December, 1998 and included 10 recommendations that paved the way for the passage of HB 1444.

HB 1444 funding is contained in HB 1676 which relates to permanent funds for certain public health purposes. HB 1676 establishes a permanent fund for children and public health. This children and public health fund allows for money to be spent to accomplish a number of purposes including "grants to local communities for essential public health services as defined in the Health and Safety Code." HB 1444 requires TDH to make grants available to counties, municipalities, public health districts, and other political subdivision to deliver essential public health services. Grants must be distributed equally between urban and rural communities.

Five million dollars was appropriated annually for the permanent fund for children and public health for the next biennium. The Texas Board of Health may adopt rules governing any grants program under this fund. The portion of the permanent funds that will be available to fund HB 1444 has not yet been determined.

TDH staff delineated the following major tasks and some time lines in implementing HB 1444:

1. Developing implementation strategies with stakeholders.
August 25, 1999: a meeting is scheduled with stakeholders to discuss ideas for rulemaking and implementation for HB 1444 essential public health grants.
2. Rulemaking.
September, 1999: draft rules will be shared with stakeholder volunteers and posted on TDH web site for written comment.
October/November, 1999: revised rules will be posted in the Texas Register for public comment
January, 2000: rules will be presented to Board of Health
February, 2000: rules will go into effect (20 days after Board of Health meeting)
3. Developing TDH strategy for allocating funds.
November, 1999/ February, 2000: draft and post RFPs.
4. Developing and executing grants to local governments
5. Establishing the consortium
6. Evaluating the first grant cycle and reporting to the legislature

Welfare Reform

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

Other Key Health Legislation and Appropriations from the Texas 76th Legislature

See Table below.

Summary of Bill	
Bill No.	
SB 30	<ul style="list-style-type: none"> Requires parental notification of abortion for minor Allows counties to bill TDH for judicial bypass court costs Requires Board of Health to develop physician reporting form for emergency abortions by 12/15/99
SB 374	<ul style="list-style-type: none"> Transfers the Medically Dependent Children Program to DHS by 9/1/2001 Creates Workgroup on Children's Long Term Care and Health Programs to assist HHSC, DHS and TDH in creating a system to administer long term care for children. HHSC to appoint members by 12/1/99 with TDH sharing administrative support with TDHS; first report due by 9/1/2000 Creates new CSHCN health benefit plan similar to CHIP; redefines "CSHCN"; removes
SB 397	<ul style="list-style-type: none"> Requires all entities receiving state funds for health and human service to provide information about services to the Texas Information and Referral Network at HHSC
SB 445	<p>CHIP Bill</p> <ul style="list-style-type: none"> Covers ages 0 through 18 up to 200% FPL, subject to review and availability of funding HHSC responsible for policy; may direct TDH to adopt necessary rules to implement health plan contracts; monitor plan providers to ensure quality; monitor quality through use of outcome measurements; and pay health plans Provides for 12-month continuous eligibility Requires benefits for CSHCN as well as healthy children
SB 519	<ul style="list-style-type: none"> Mandates HepB prenatal and perinatal testing
SB 602	<ul style="list-style-type: none"> Requires TDH to coordinate with the Interagency Council for Genetic Services for initiating, considering, or proposing a rule relating to human genetics or
SB 1585	<ul style="list-style-type: none"> Requires competitive bidding for processing claims in the Medicaid vendor drug program
SB 1591	<ul style="list-style-type: none"> Requires TDH and other health and human services agencies to implement national standards for the electronic processing of health care and health payment information within federal deadlines or report reasons for non-compliance to HHSC Requires HHSC and Texas Health Care Information Council to develop plan to
SB 1586	<ul style="list-style-type: none"> Requires HHSC to develop voucher program for state- and Medicaid-funded personal assistance and respite services for persons with disabilities Requires HHSC to create Voucher Payment Program Workgroup including
Summary of Bill	
Bill No.	
SCR 79	<ul style="list-style-type: none"> Requires TDH to take lead, in collaboration with other agencies, to study cause and prevention of school violence

<p>HB 494</p>	<ul style="list-style-type: none"> Requires Medicaid recipients to exhaust drug benefits under Medicaid program prior to claiming benefits under CIDC and Kidney Health Programs Requires TDH to create a voluntary drug rebate program for CIDC and KHC by 9/1/99 and to consolidate drug claims with TDH Vendor Drug Program by 	<p>3/1/2001</p> <ul style="list-style-type: none"> Requires drug rebate funds to be appropriated to KHC and CIDC TDH Rider 68 appropriates \$1.6 million out of rebates revenues to implement program contingent on receipt of \$1.9 million in rebates
<p>HB 714</p>	<ul style="list-style-type: none"> Requires birthing facilities in counties w/> 50,000 and ≥100 births per year to offer hearing screening to newborns TDH may certify screening programs; must maintain data; ensure access to ECI services; and provide technical assistance and data/tracking software to Medicaid facilities Requires inclusion of newborn hearing screening services under Medicaid and any health benefit plan covering children 	<ul style="list-style-type: none"> \$2.8 million/biennium appropriated from tobacco funds for TDH data/tracking costs Bill effective 9/1/99; services to be offered by facilities with ≥1,000 births/year by 5/1/2000, by all required facilities by 4/1/2001 TDH must adopt rules for certification by 12/1/99 HHSC/TDH must adopt rule for Medicaid coverage by 1/1/2000 subject to need for federal waiver or approval
<p>HB 908</p>	<ul style="list-style-type: none"> Requires TDPRS to consult with TDH on rules to ensure children in licensed child care facilities receive required vision and hearing screening Requires TDPRS to adopt protocol agreement with TDH for coordinating 	<p>monitoring inspections</p> <ul style="list-style-type: none"> As soon as possible after effective date of act (6/19/99)
<p>HB 985</p>	<ul style="list-style-type: none"> Requirements for state agency EBT programs to comply with Interagency Task Force on EBT strategic guidelines 	
<p>HB 1151</p>	<ul style="list-style-type: none"> Continuation of Office for Prevention of Developmental Disabilities To be administratively attached to MHMR; effective 9/1/99 	<ul style="list-style-type: none"> Sunset Commission to decide by 9/1/2001 if Office should be continued or should become part of MHMR
<p>HB 1285</p>	<ul style="list-style-type: none"> Requires parent, guardian, or adult authorized by parent to accompany child <age 15 receiving Medicaid visit or screen (except for school health facilities, 	<p>Head Start, and child care facilities if written consent already provided)</p> <ul style="list-style-type: none"> Effective 9/1/99; subject to any necessary federal waiver.
<p>HB 1387</p>	<ul style="list-style-type: none"> Requires TDH to pay for SIDS autopsies subject to availability of funds Requires TDH to adopt rules defining “SIDS” and describing method for 	<p>reimbursement of SIDS autopsy</p> <ul style="list-style-type: none"> Effective for any SIDS death occurring on/after 9/1/99.
<p>HB 1444</p>	<ul style="list-style-type: none"> Defines “Essential Public Health Services” Requires TDH to make grants, subject to available funds, to counties, municipalities, public health districts, and other political subdivision to deliver essential public health services; to be divided equally between urban and rural; based on a plan developed by the local entity; may be overseen by an existing or appointed local health board Permits TDH, subject to available funds, to provide essential public health services to local entities not receiving a grant 	<ul style="list-style-type: none"> Creates Consortium, subject to availability of funds, to consist of representatives from all six University of Texas health centers; and Texas Tech University, Texas A&M, and University of North Texas health centers Requires TDH, with cooperation from local grantees and Consortium, to file biennial report evaluating the grant program Requires Consortium, subject to availability of funds, to develop curricula and competency certification standards for public health workers; conduct research on improving health status; develop performance standards for local health departments and public health districts; and study technology infrastructure of local entities to improve statewide communication and access to information.
<p>Rider 4</p>	<ul style="list-style-type: none"> Rider 4 limits transfer of unexpended appropriated general revenue funds in CSHCN strategy either to County Indigent Health Care or Medicaid strategies 	

Bill No.	Summary of Bill	
HB 1864	<ul style="list-style-type: none"> Requires TDH to create a temporary committee to study the development of a Promotora Outreach Program and feasibility of a federal waiver with TDH to provide staff support; and Committee report due to TDH, legislature and governor's office by 12/31/2000 Requires Committee to make recommendations and develop a strategic plan to address barriers encountered by Medicaid recipients in accessing prenatal and neonatal health care services with report due to TDH, legislature, and the governor's office by 12/31/2000 	<ul style="list-style-type: none"> Allows Medicaid and CHIP to establish pilots to demonstrate feasibility and benefits of employing promotoras with grants to be provided by HHSC subject to availability of appropriations Requires TDH to establish a promotora training and certification program by 1/1/2000; and Board of Health shall adopt rules by 12/1/99
HB 2085	<ul style="list-style-type: none"> TDH Sunset bill effective 9/1/99 Requires full integration of primary health care, maternal and child health, chronically ill and disabled children's services, and Medicaid services; and report on integration by 9/1/2002 	<ul style="list-style-type: none"> Conduct a pilot integrating Medicaid and non-Medicaid services identified above; to begin by 9/1/2000 and end 9/1/2001; with interim report due 9/1/2000 and final report 9/1/2002
SCR 6	<p>Creates a Blue Ribbon Task Force to</p> <ul style="list-style-type: none"> study issues of uninsured Texans targeted to persons with asthma, cardiovascular disease, smoking related illnesses, or diabetes review demographic trends 	<ul style="list-style-type: none"> evaluate existing programs that address uninsured or indigent health care needs develop market-based improvement plan be governed by interim committee rules and policies
HB 2148	<ul style="list-style-type: none"> Requires HHSC to set uniform certain functions of Medicaid 1915(c) waiver programs Requires HHSC to develop and implement a pilot to assess consolidation of 	<p>1915(c) waiver program; limited to specific geographic area and persons not currently served by waiver programs; report to legislature due by 1/1/2004</p>
HB 2202/ Rider 54 /Cont. Rider 9-11.19	<ul style="list-style-type: none"> Permits school districts to establish school health center (SHC) with assistance from any public health agency in the community, which must cooperate to extent practical Requires SHCs to coordinate with existing health care systems and medical relationships in the community if located in county with < 50,000 or in a medically under served area Requires SHC to notify student's primary care physician prior to providing a service and obtain approval if student is covered by Medicaid, CHIP, private health insurance, or a private health benefit plan Permits TDH to fund SHCs @ \$250,000 per district for biennium with preference for school districts in rural areas or those with low property wealth per student 	<ul style="list-style-type: none"> Requires TDH to issue annual report on efficacy of services delivery by SHCs including increased attendance, decreased dropout rates, improved student health, and improved assessment scores Requires TDH to adopt rules to implement grant program Requires TDH to adopt rules establishing standards for SHCs receiving grants Rider 54 appropriates \$3.2 million/biennium to fund school health services and requires TDH to award at least two contracts per contract award period during biennium Cont. Rider 9-11.19 allows \$150,000 per FY out of appropriated funds to be expended on grants to start-up or stabilize SHCs
HB 2873	<ul style="list-style-type: none"> Requires certain processes for Medicaid waiver programs for children with disabilities or special care needs including permanency planning, needs assessment, coordination of services, planning for transition out of a service, 	<p>equitable eligibility requirements</p> <ul style="list-style-type: none"> Requires HHSC to create an advisory committee
HB 3271	<ul style="list-style-type: none"> Requires IV-D Agency to establish an Interagency Workgroup, including TDH, to facilitate sharing of information on locating parents of recipients 	<ul style="list-style-type: none"> Effective 9/1/99
HCR 0096	<ul style="list-style-type: none"> Directs HHSC to access federal TANF funding for Medicaid outreach 	
Rider 17	<p>Consent for Medical Treatment</p> <ul style="list-style-type: none"> Requires compliance with Chapter 32 of the Family Code for delivery of any medical, dental, psychological, or surgical treatment provided to a minor 	<ul style="list-style-type: none"> Requires prior approval of Governor and LBB if TDH needs to modify rider to avoid loss of federal funds

Bill No.	Summary of Bill	
Rider 18	Reporting Child Abuse <ul style="list-style-type: none"> Requires TDH to ensure recipients of funds make a good faith effort to comply with child abuse reporting requirements of Chapter 261, Texas Family Code 	
Rider 54	School Health Expenditures <ul style="list-style-type: none"> Requires TDH to expend either 3% of total expenditures in MCH Services Strategy D.1.1 or \$3,241,189, whichever is greater, for school health services 	<ul style="list-style-type: none"> Requires TDH to continue awarding at least two new contracts per contract award period of the biennium for school health services
Rider 57	Dental Provider Participation <ul style="list-style-type: none"> Requires TDH to certify the change in enrollment and participation of Medicaid dental providers to Governor and LBB by July 1, 2000 	
Rider 58	PKU Pilot Program <ul style="list-style-type: none"> Requires TDH to use \$150,000 in FY00 and \$150,000 in FY01 out of appropriated funds to conduct a pilot project to assess the cost and effectiveness of providing 	medically indicated medical foods to children ages 0 to 5 affected with PKU.
Rider 59	GR Match for Abstinence Education <ul style="list-style-type: none"> Requires TDH to transfer \$1.6 million per FY to Abstinence Education strategy D.1.5 out of available GR in Goal F, including Earned Federal Funds, to meet state and local matching requirements for locally operated abstinence 	education programs. <ul style="list-style-type: none"> Requires TDH to report to Governor and LBB by July 1 preceding each FY on source and type of funds to be transferred.
Rider 68	Contingency Appropriation for HB 494 (CIDC/KHC Drug Rebate Program) <ul style="list-style-type: none"> Contingent on enactment of HB 494 or similar legislation and generation of \$1.9 million in drug rebate revenues over the biennium 	<ul style="list-style-type: none"> Appropriates \$814,946 for FY00 and \$814,946 for FY01 out of rebate revenues for purpose of implementing drug rebate program
HHSC Rider 12	Recycling of Nursing Home Drugs <ul style="list-style-type: none"> TDH to collaborate with HHSC (lead agency), DHS, and State Board of Pharmacy to study recycling of nursing home drugs Study to identify each state and federal law, rule and regulation that would 	require change to implement AMA recommendations <ul style="list-style-type: none"> Report due by 9/1/00 to Governor, Lt. Governor., House Speaker, and Chair of each legislative committee with jurisdiction over long-term care or pharmaceuticals

Since it became a state, Texas has grown at a faster rate than the U.S. as a whole. According to the U.S. Census, Texas' population was 16,986,510 in 1990; and in 1998, the population was 19,760,000 residents. One growth scenario indicates the state's population will be 33.9 million in 2030 (Source: *Texas Challenged: The Implications of Population Change for Public Service Demand in Texas*, 1996, updated with 1999 Texas State Data Center projections). In addition, projected growth rates will significantly change the state's demographic make-up. Between 1990 and 2030, the Hispanic population is expected to increase by 261%; the African-American population by 62.1%; and the Anglo (non-Hispanic white) population by 19.8%. The same projections indicate that by 2017, Anglos will be less than 50% of the total population, and no one ethnicity will be in the majority. In all, 87.5% of the projected growth in Texas population will be related to growth in the minority population. Expected increases in the number of children suggest the continuing need for preventive and primary care child health services (Source: TDH Bureau of State Health Data and Policy Analysis).

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

State Government Context

TDH, the state health agency responsible for the Title V program, is one of 11 state health and human services agencies under the umbrella of the Texas Health and Human Services Commission (HHSC). The HHSC has responsibility for reviewing and approving TDH's strategic plan and legislative appropriations request prior to its submission to the Legislative Budget Board and Governor. In addition HHSC is the single state Medicaid agency, and TDH is responsible for submitting proposed Medicaid rules for HHSC review and approval. Legislation passed in the recent session gives HHSC increased control over agency operations through supervision of the commissioner of health.

TDH Reorganization

During FY 1999, TDH continued a phased implementation of a department-wide reorganization (Appendix C) to align the agency with the TDH strategic directions. Phase 1 centered on creation of two new deputyships and appointment of two deputy commissioners to head the new areas: 1) Community Health and Prevention, and 2) Public Health Sciences and Quality. The Deputyship for Community Health and Prevention concentrates on what TDH can do to build community relationships within and outside TDH. This area also encourages people to adopt behaviors that contribute to health, reduce behaviors that put people at risk, and help create environments and relationships that are conducive to health. The Deputyship for Public Health Sciences and Quality concentrates on the science needed to: skillfully investigate outbreaks, track disease and injury trends, protect public health through regulatory oversight, and measure prevention program outcomes. Mr. John Evans has been appointed deputy commissioner for Community Health and Prevention in which the Title V program is located.

During fall 1998, TDH implemented Phase 2 of the reorganization. The agency convened a department-wide reorganization team to study all department programs and how they should logically fit under each of the four deputyships. The team reviewed a proposed reorganization chart as well as

existing program information and gathered new information to make recommendations for the placement of Associateships, Bureaus and Programs below the Deputyship level. The majority of the team's recommendations were adopted.

Currently, each Deputyship is involved in implementing Phase 3, a closer review of Associateship, Bureau, Division and Unit-level programs and functions. The Deputyship for Community Health and Prevention has established three work teams to address issues related to reorganization and toward operationalizing the TDH strategic directions: community-based solutions; emphasis on prevention; focus on outcomes; and TDH as a state leader.

Under this reorganization, no major changes have occurred for Title V program operations, most of which are located in the same Associateship (Appendix D). The name of the Associateship has been changed from Health Care Delivery to the Associateship for Community Health and Resources Development. Dr. Jack Baum, Title V director for MCH, has been appointed acting Associate Commissioner and has moved out of his former position as Chief, Bureau of Children's Health. Ms. Kathleen Hamilton has been appointed acting Chief, Bureau of Children's Health. Some divisions have been moved within the Associateship, and as Phase 3 is implemented, more changes may take place. Qualifications of senior level management are in Appendix E.

State Statutes

TDH has provided health services for women and children since 1918 and services to CSHCN since 1933. Eleven state statutes directly relate to MCH and CSHCN program authority: 1) the Maternal and Infant Health Improvement Act (MIHIA), Chapter 32 of the Texas Health and Safety Code (HSC); 2) the Chronically Ill and Disabled Children's Program (Chapter 35, HSC); 3) the Newborn Screening Program (Chapter 33, HSC); 4) the Special Senses and Communication Disorders Act (Chapter 36, HSC); 5) the Spinal Screening program (Chapter 37, HSC); 6) the Radiation Control Act (Vernon's Texas Civil Statutes, Chapter 4590f); 7) the Midwifery Act (Vernon's Texas Civil Statutes, Article 4512i); 8) the Oral Health Improvement Act (Chapter 43, HSC); 9) the Distribution of Child Passenger Safety Seat Systems Act (Chapter 45, HSC); 10) the Injury Prevention and Control Act (Chapter 88, HSC) which establishes a list of reportable injuries, including spinal cord and submersion injuries, and elevated childhood blood lead levels; and 11) the Sudden Infant Death Syndrome Act.

Maternal and Infant Health Improvement Act

In 1985, the Texas Legislature passed MIHIA, which enabled TDH to establish a model health care program offering a comprehensive array of perinatal services to low-income, high-risk, pregnant women and infants who were not eligible for Medicaid. In 1995, the Texas Legislature passed Senate bill (S.B.) 1229 to amend MIHIA. S.B. 1229 supported health improvements for women and infants by promoting health education, providing assurance of reasonable access to safe and appropriate perinatal services, and improving the quality of perinatal care by encouraging optimal use of health care resources. TDH is establishing minimum standards and objectives to implement and monitor a statewide network of voluntary perinatal health care systems. TDH will further develop policies for health promotion and education, risk assessment, access to care, and perinatal system structure including the transfer and transportation of pregnant women and infants. Finally, TDH will develop and maintain a perinatal reporting and analysis system to monitor and evaluate perinatal patient care in the systems, and TDH will promote coordination and cooperation within Texas and among neighboring states for perinatal care.

Chronically Ill and Disabled Children's Services Program

Under Chapter 35, TDH provides services to eligible CSHCN and their families under the Chronically Ill and Disabled Children's Services (CIDC) program. Basic services include: early identification, diagnosis and treatment, rehabilitation services (inpatient and outpatient medical services), development and improvement of standards and services for children with special health care needs, and case management services.

The 76th Texas Legislature changed the name from CIDC to the Children with Special Health Care Needs program. The name change will be effective September 1st, 1999 (see pages 12-15 regarding legislation from the 76th legislature that affects CIDC program).

Newborn Screening Program

In 1965, the Texas Legislature passed legislation establishing the Newborn Screening Program and gave TDH the authority to implement the program. All Texas newborns are screened for phenylketonuria (PKU), galactosemia, sickling hemoglobinopathies (including sickle cell disease), congenital adrenal hyperplasia, and hypothyroidism. All newborns who have been screened and found to be presumptively positive for heritable diseases receive follow-up. Families at or below 200% of FPL may receive CIDC services, including medical care, case management, and necessary dietary supplements. Individuals with PKU may receive dietary supplements at no cost or reduced cost, based on family income. In 1989, the 71st Legislature amended Chapter 31 of the Insurance Code to provide for health insurance coverage for PKU formula, similar to that for prescription drugs. The 76th Texas Legislature appropriated a small amount of funding to pilot the use of medical foods in managing PKU.

Special Senses and Communication Disorders Act

In 1989, the 71st Texas Legislature passed the Special Senses and Communication Disorders Act. The Act's purpose was to establish a program to identify, as early as possible, those individuals from birth to 20 years of age who have special senses and communication disorders and who need remedial vision, hearing, speech, and language services. Early detection and remediation of those disorders provide the individuals with the opportunity to achieve appropriate academic and social status through adequate educational planning and training.

Another requirement under Chapter 36 is the registration of audiometer equipment with TDH. The Bureau of Children's Health Audiometric Laboratory provides support for the Vision and Hearing Screening program by annually calibrating and repairing the 666 audiometers owned by TDH; and by loaning TDH-owned audiometers to day care centers, private schools, small school districts, and home school groups for hearing screening to comply with state requirements.

Finally, HB 714 of the recent legislation session requires birthing facilities in counties with populations greater than 50,000 and with more than 100 births per year to offer hearing screening to newborns. TDH is responsible establishing certification criteria for hearing screening programs and to provide technical assistance and data/tracking software to Medicaid facilities.

Texas Radiation Control Act

Under the Texas Radiation Control Act and the standards promulgated by the American National Standards Institute, the TDH Audiometric Laboratory has statewide responsibility for assuring the quality of equipment used to test hearing for all Texans. The program registers and maintains a database listing equipment used to test hearing and those who use it (e.g., nurses, audiologists,

hearing aid dealers, physicians), as well as monitoring the calibration performed by private equipment companies in Texas to ensure accuracy. Audiometric laboratory staff conduct on-site visits to monitor audiometer calibration.

Abnormal Spinal Curvature in Children Act

Under Chapter 37 (the Abnormal Spinal Curvature in Children Act), the TDH Spinal Screening Program facilitates the detection of abnormal spinal curvature in children through spinal screening in Texas schools. The program: 1) provides training and certification to spinal screener instructors and spinal screeners; 2) approves spinal screening training programs; 3) establishes standard spinal screening tests and referral criteria; 4) coordinates spinal screening activities of school districts, private schools, and other entities involved in spinal screening; 5) monitors the quality of spinal screening activities in Texas; 6) issues reporting forms; 7) provides educational materials to assist spinal screening activities; and 8) maintains records of approved instructors and screeners.

Midwifery Act

Under Vernon's Texas Civil Statutes (Article 4512i), TDH is responsible for administering the Midwifery Program. The program assures annual documentation of direct entry midwives (as distinguished from certified nurse-midwives) and interacts with the Midwifery Board and its committees. The Midwifery Program maintains a roster of annually documented midwives, publishes a basic midwifery information manual, compiles midwifery statistics, and processes complaints against midwives. The Midwifery Program is advised by the Midwifery Board which is appointed by the Board of Health. The Midwifery Board investigates and resolves complaints against midwives; approves rules and standards of practice for midwives, and advises the Board of Health on other midwifery matters. The Midwifery Board also approves basic midwifery courses, certification exams and continuing education courses. The Midwifery Program assists the Midwifery Board and its committees as required under TAC §37.171-184.

Oral Health Improvement Act

Under Chapter 43, HSC, TDH is responsible for establishing the Oral Health Improvement Services Program to provide comprehensive oral health services to eligible individuals. Oral health services include direct care preventive and treatment services, fluoridation of community water supplies, oral health education and promotion activities, sealants programs, continuing health education programs for providers, public health education in preschools, schools and adult education programs, outreach activities to promote awareness of oral health services programs, and activities to address provider availability across the state. The program may conduct field research and prepare reports relating to the need for and availability of oral health services. The Board of Health must adopt program rules and prescribe a system of program priorities regarding the types of services to be provided, the geographic areas covered, and the classes of individuals eligible for services. The program is permitted to use existing public and private resources. TDH is not required to provide services unless funds for oral health services are appropriated to TDH.

Child Passenger Safety Seat Systems

Chapter 45 HSC permits TDH to establish a program to distribute child passenger safety seats to indigent persons and allows the Board of Health to adopt program eligibility rules.

Injury Prevention and Control

Chapter 88 HSC establishes a list of reportable injuries, which include spinal cord and submersion injuries and elevated childhood blood lead levels. The Board of Health has the authority to establish rules to designate blood lead concentrations and ages of children that must be reported. TDH has the authority to seek, receive, and spend funds on identifying, reporting, and preventing injuries; to conduct epidemiological studies; to evaluate trends; to make inspections and investigations; and to establish a childhood lead registry.

Sudden Infant Death Syndrome (SIDS)

Chapter 673 (HSC) requires that the death of a child under two years of age must be reported to the justice of the peace, coroner, medical examiner or other proper official if the child dies suddenly or is found dead and the cause of death is unknown. The official is required to inform the child's parents/guardians that they may request an autopsy and that the state (TDH) will pay the autopsy costs. The law states that SIDS may be used as a primary cause of death on a death certificate and also requires TDH to develop a model program to provide information and follow-up consultation about SIDS and to promote public awareness and understanding of SIDS.

Finally, HB 1387 of the 76th Texas Legislation requires TDH to pay for SIDS autopsies (subject to availability of funds) and to adopt rules defining "SIDS" and describing method of reimbursement of SIDS autopsy.

1.5.1.2 Program Capacity

Overview

In FY 1999, the Texas Title V program budgeted \$124,785,572 in Title V and general revenue funds for direct, enabling, population-based and infrastructure building activities around preventive and primary care services for pregnant women, mothers and infants, children, and children with special health care needs. The majority of MCH services are provided through contracts with providers including local health departments, universities, hospital districts and individual providers. The majority of CSHCN services are provided by enrolled providers. Some services are provided directly by TDH through central office or public health regional units.

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

Preventive and primary care services for pregnant women, mothers, and non-pregnant women include: prenatal services (initial, return and postpartum visits, ultrasound, nutritional and case management) family planning services (initial visit, pregnancy test, depo-provera, oral contraceptive, IUD insertion/removal, norplant insertion/removal, tubal ligation and vasectomy, nutritional, annual gynecology examination); dysplasia services (initial and return visits, colposcopy, colposcopy and biopsy, and conservative treatment).

Preventive and primary care services for infants include well child, sick child and follow-up visits; nutritionist visits, and case management.

Preventive and Primary Care Services for Children

Preventive and primary care services for children include well child, sick child and follow-up visits;

nutritionist visits, and case management, as well as the prenatal and family planning services listed above, as needed. Title V provides funding for dental services (preventive services and restorative treatment) for children. Texas also has a school health program that provides start-up funding for model school health centers to provide health, social, and mental health services to children and adolescents; and which facilitates community planning and implementation of school health services. In addition, Title V administers newborn screening, genetic services, pre-school vision and hearing program, and the Program for the Amplification of Children of Texas.

Services for Children with Special Health Care Needs

TDH operates the CIDC program, which provides examination; diagnosis and treatment; hospitalization; braces and artificial limbs; medicine; equipment; medical supplies; speech, physical, and occupational therapy; and meals, transportation, and lodging to receive medical treatment. TDH provides CIDC intake, eligibility, claims processing, and record-keeping functions associated with services provided. CIDC services are available for eligible children who have specific diagnoses from birth through 21 years (except clients with cystic fibrosis, who are eligible for services beyond age 21). Generally "covered" conditions include: bone, muscle, and joint problems; cardiovascular and neurological disorders; cleft lip, cleft palate, or other craniofacial anomalies; congenital anomalies of the gastrointestinal tract; cystic fibrosis; cancer, certain blood disorders including hemophilia and sickle cell disease; certain hearing and eye disorders; congenital anomalies of the genitalia and genitourinary tract, but not kidney problems; and severe burns.

During FY 1999, the Bureau of Children's Health initiated a pilot program for children with Type 2Y diabetes. The program provides reimbursement for medical care, medications, and monitoring equipment and supplies. At the same time, the Bureau of Children's Health, Children with Special Health Care Needs Planning and Policy Development Division is working with the TDH Diabetes Program and Council on a population-based activity to complement the new direct services being offered. This activity focuses on encouraging school children to increase their physical activity and improve their nutrition.

Rehabilitation Services for Blind and Disabled Individuals Under 16 Receiving SSI

The Social Security Administration contracts with the Texas Rehabilitation Commission (TRC) to conduct disability determinations for SSI. The applications of eligible children are sent to TDH, Bureau of Children's Health, Case Management Section, for distribution to the TDH regional offices. Regional office staff contact all families of SSI-eligible children via telephone or mail and arrange for services as needed. Regional social workers work closely with TRC in the provision of services, with special emphasis on each child's transitional needs.

All children under 16 receiving SSI are entitled to receive Medicaid services and Title V case management services. TDH provides case management services through contracts and some services are provided directly by TDH through public health regional staff. The Case Management Section of the Genetic Screening and Case Management Division develops policies and manages many of the case management contracts, including Medicaid Pregnant Women and Infants (PWI), the Texas Health Steps (formerly EPSDT) case management services for CSHCN, and Title-V funded Title V case management services to PWI, children and CSHCN who do not qualify for Medicaid. A

key purpose of these programs is to provide and promote family-centered, community-based, coordinated care, including care coordination services for CSHCN. These programs also facilitate the development of systems of care for CSHCN and their families. All Texas SSI-eligible children are automatically eligible for Medicaid, unless their family incomes exceed Medicaid limits. The Texas CSHCN program (Chronically Ill and Disabled Children program) provides services to SSI beneficiaries who become ineligible for Medicaid.

Development of Systems of Care

The Bureau of Children's Health is actively involved in developing systems of care for all children, including CSHCN. Staff provide leadership for CIDC and Medicaid child health policy and standards development, participate in interagency coordination projects for CSHCN health systems development, and leverage grant funding to conduct research and develop demonstration projects for CSHCN and their families. Staff are involved in development and roll-out of Medicaid managed care, including demonstration projects for CSHCN. As stated earlier, staff are also actively involved in developing the CHIP program.

During summer 1998, the Texas Senate Interim Committee on Children's Health Insurance, the Texas House Committee on Appropriations, and Texas House Committee on Public Health held a joint hearing on the Children's Health Insurance Program (CHIP). At the hearing, the staff of the Legislative Budget Board (LBB) was asked to compile information on eligibility, services, and waiting lists for programs providing health services to children. All Texas Health and Human Services programs identified as providing health services to children were asked to complete a survey whose purpose was to identify health services for children who may qualify for funding through CHIP. The completion of the survey required two levels of analysis: 1) by type of services (in-patient hospital, private duty nursing, counseling/therapy, durable medical equipment, medications, dental, and others); and 2) by federal poverty levels: 200%, 185%, 150%, 133%. Both levels of analysis asked for the number of children served and the corresponding state/federal fund expenditures.

Discussions at the 76th Texas Legislature used the information gathered through the completed surveys in the design and passage of SB 445. This CHIP Bill:

- covers ages 0 through 18 up to 200% FPL, subject to review and availability of funding
- makes HHSC responsible for policy; may direct TDH to administer health plan contracts
- provides for 12-month continuous eligibility for CHIP coverage
- requires benefits for CSHCN as well as healthy children
- retains right to first dollars from tobacco settlement
- creates state-funded CHIP for legal immigrant children not covered by Title XXI
- must be implemented by 9/1/00.

From January to May, 1999, Title V staff responded to numerous requests for information and analysis from the 76th Texas Legislature. At the same time, they assessed the impact of these requests on Title V programs and populations in the event that related statutes were enacted by the end of the session. Below is a brief summary of the projects Title V staff will undertake during the next biennium as a result of the legislative session. These projects involve the development and/or revision of program rules, study analysis, and systems of care development.

- CSHCN program rules must be revised to provide access to health benefits plan coverage similar to CHIP and the program should remove the assets test and diagnosis-specific eligibility. Also,

CSHCN program is responsible to develop more family support services.

- As CHIP Phase II evolves, TDH staff may be directed by HHSC to adopt necessary rules to implement health plan contracts, to monitor plan providers to ensure quality, to monitor quality through use of outcome measurements, and to pay health plans.
- Effective September 1, 1999, birthing facilities in counties with populations greater than 50,000 and with more than 100 births per year will be mandated to screen all newborns for hearing loss prior to hospital discharge. TDH Title V and Medicaid programs will be responsible establishing certification criteria for programs, maintaining data, ensuring access to ECI services, and providing technical assistance and data-tracking software to facilities, which serve Medicaid newborns .
- TDH Sunset Bill requires TDH to develop a comprehensive strategic and operational plan focusing on the integration of primary health care, maternal and child health, chronically ill and disabled children's services, and Medicaid services. In addition, the bill requires TDH to study comprehensively the impact that the state's Medicaid managed care program has had on each of the populations served by the department and on all health care providers, clinics, and hospitals.
- TDH staff should develop rules to govern the administration of grants to communities for essential public health services. Also, TDH is required to establish a public health consortium of health science facilities to develop curricula to train public health workers, conduct research on health status outcomes, develop performance standards for local public health entities, and improve the existing technology infrastructure available to local public health entities.
- Title V should make necessary changes into the current budget mechanism to comply with Rider 4 of the Appropriations Act, which stipulates that unexpended general revenue balances in the CSHCN program strategy cannot be transferred to the MCH program strategy. In addition, the rider maintains the same language from the previous biennium, which required TDH to make expenditures from state funds for CSHCN services program in proportion to the Title V funds budgeted for the program.

As these projects evolve, stakeholders' input will be crucial in developing efficient and effective systems of care. Therefore, beginning in Fall 1999, Title V leadership will initiate a stakeholder communication process to build a common knowledge base, a shared understanding, and a unified proposal for the future of all types of MCH/CSHCN services. Regional and statewide meetings with Title V MCH and CSHCN stakeholders will provide a forum and process for education, networking, consensus building around the future of Title V programs, and development of proposals that address critical short-, mid- and long-range issues. Stakeholders include public health region office staff, contractors, public health leaders and interest groups (i.e., Board of Health and professional and advocacy organizations), and MCH and CSHCN services consumers. More information about the Title V stakeholder meetings process is included in Appendix F.

1.5.1.3 Other Capacity

Tables 1 and 2 provide the number and types of full-time equivalent personnel funded by the federal-state Title V program. This information is based on the Title V administrative allocation budget for FY2000 as of April, 1999. Table 1 shows a total of 293 positions funded with federal Title V and state general revenue funding in the Associateship for Community Health and Resources Development

(TDH Central Office in Austin). Table 2 shows a total of 326 positions funded with federal Title V and state general revenue funding in TDH Public Health Regional Offices. Appendix C contains summaries of the qualifications of senior level employees. Nine parents of CSHCN serve on the TDH CSHCN Advisory Committee (Appendix G). Their role is to advise the Board of Health as well as the Bureau of Children's Health on policies, programs, and systems development for CSHCN and their families.

Table 1 Central Office Title V Positions	
Position Type	Number
Accountant	5
Accounting Clerk	3
Administrative Tech.	66
Chemist	3
Clerk	3
Clinical Social Worker	1
Contract Specialist	1
Data Base Admin.	3
Data Entry Operator	4
Executive Assistant	6
Laboratory Tech.	4
Medical Technologist	25
Microbiologist	36
Network Specialist	7
Nurse	18
Office Mach Service Tech.	1
Exempt (physicians, others)	29
Planner	2
Program Administrator	12
Program Specialist	12
Programmer	7
Public Health Tech.	6
Purchaser	2
Research Specialist	3
Secretary	2
Staff Services Officer	3
Statistician	3
Stock & Inventory Clerk	1
Systems Analyst	3
System Support Specialist	4
Training Specialist	1
Total	276 *

* includes Integrated Client Eligibility Systems, Automated Data Systems, Injury Prevention and Control Program, Birth Defects Monitoring Program, Cytology Lab-San Antonio, Genetics Lab-Denton, and TDH Lab-Austin.

Table 2 Public Health Regional Office Title V Positions									
	PH R 1	PHR 2/3	PHR 4/5	PHR 6	PHR 7	PHR 8	PHR 9/10	PHR 11	Total
Accountant	0	0	0	0	0	0	0	1	1
Accounting Clerk	0	0	0	1	0	0	0	0	1
Administrative Tech.	0	2	2	8	7	4	6	9	38
Caseworker	0	1	0	0	0	0	0	3	4
Clerical Supervisor	1	0	0	0	0	0	0	1	2
Clerk	0	0	10	3	7	7	2	8	37
Contract Specialist	0	0	0	1	0	0	0	0	1
Custodian	0	0	0	0	0	0	0	1	1
Epidemiologist	0	1	0	0	0	0	0	0	1
Human Service Tech.	2	5	2	4	3	13	9	12	50
Laboratory Tech.	0	0	0	0	0	0	0	1	1
Licensed Voc. Nurse	0	0	0	0	0	2	0	9	11
Medical Aide	0	0	0	0	0	0	0	3	3
Nurse	2	6	5	9	12	11	16	14	75
Nutritionist	0	0	2	1	0	0	0	0	3
Pharmacy Tech.	0	0	0	0	0	0	0	2	2
Program Administrator	2	4	3	0	2	3	5	3	22
Program Specialist	0	2	1	6	1	1	0	2	13
Public Health Tech.	0	0	1	0	0	0	1	0	2
Purchasing Clerk	0	0	0	0	0	0	0	1	1
Radiological Tech.	0	0	0	0	0	0	0	1	1
Secretary	0	3	0	0	1	0	0	1	5
Social Srvc Prog. Cons.	3	13	11	11	6	9	4	10	67
Stock & Inventory Clerk	0	0	0	0	1	0	0	0	1
Total	10	37	37	44	40	50	43	82 *	343 **

* includes South Texas Women's Hospital - Harlingen
** includes Local Health Departments

1.5.2 State Agency Coordination

State Agencies

In 1991, the Texas Legislature passed H.B. 7, which reorganized the administrative structure of the state's health and human service agencies. The bill created the Health and Human Services Commission (HHSC) to serve as an umbrella agency to coordinate 11 health and human services agencies and to assume responsibility for Medicaid policy as the single state Medicaid agency. HHSC has responsibility for coordinating development of joint strategic plans and a consolidated budget for these agencies. Altogether, H.B. 7 and HHSC have significantly increased joint planning and interagency coordination in health and human services.

From 1997-1999, HHSC underwent the state Sunset Review Process to determine if HHSC functions are still needed, and to determine if changes are needed. The 76th Texas Legislature passed HB 2641 to continue HHSC with provisions that restructure the organizational relationships among HHSC and its constituent agencies. For example, HB 2641 empowers the HHSC Commissioner to employ the Commissioner of Health with the Board of Health's concurrence and governor's approval, requires the Board of Health to enter into an MOU with the HHSC Commissioner, and authorizes HHSC to supervise and direct activities of Commissioner of Health.

The agencies under the authority of the HHSC are: 1) Interagency Council on Early Childhood Intervention; 2) Texas Commission on Alcohol and Drug Abuse; 3) Texas Commission for the Blind; 4) Texas Commission for the Deaf and Hearing Impaired; 5) Texas Department of Health; 6) Texas Department of Human Services; 7) Texas Juvenile Probation Commission; 8) Texas Department of Mental Health and Mental Retardation; 9) Texas Rehabilitation Commission; and the 10) Texas Department of Protective and Regulatory Services. TDH and Title V program staff within the Associateship for Community Health and Resources Development have ongoing program and project-specific relationships with all the agencies under the HHSC.

COMPASS 21

In 1998, the claims administrative contractor, National Heritage Insurance Company (NHIC), in collaboration with Texas Health and Human Services programs, initiated the development of a new Client/Server claims payment system. The new Compass 21 system will replace the existing 20-year old system. Compass 21 will process claims for: Core Medicaid, CSHCN, Long-term Care, and Family Planning programs. Its goals are to: 1) reduce the claims payment cycle from 1-3 months to 1 week or less; 2) reduce rejected claims from 21% to 10%; 3) reduce ad hoc report production time from 21 days to 21 hours, and 4) respond to legislative requests within 24 hours.

Compass 21 includes several useful features. For example, it allows users to issue queries to create ad hoc reports required for effectively managing and administering the Medical assistance programs. The system also creates programmed reports and files for detecting trends that may indicate fraud and for monitoring utilization by providers and recipients. The project is scheduled to be fully implemented by November, 1999.

Local Agencies

The Title V program has longstanding contracting and collaborative relationships with local health departments (LHDs), federally qualified health centers (FQHCs), and FQHC look-alikes. LHDs and FQHCs are actively involved in local health planning, including development of coalitions for women's and children's services. Title V also maintains ongoing collaborative relationships with university-based education and clinical services programs and with tertiary care facilities. There are Title V contracts for MCH clinic services, CSHCN case management services, training, and population-based services. University and tertiary facilities are approved providers for CSHCN

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

Texas SSDI plays an important role in establishing an “information structure” that links Title V program with its stakeholders. This “information infrastructure” facilitates the exchange of electronic information between Title V programs in the Associateship for Community Health and Resources Development and local Title V contractors, community public health leaders, and consumers. To make this flow of information more effective and efficient, SSDI staff consult on an ongoing basis with local organizations and individual consumers to identify communication technology needs and resources that can be implemented. SSDI believes that when state and local public health stakeholders gain knowledge and start using electronic interfaces to obtain data and share information, they become more sophisticated in managing the state efforts toward building community systems, including infrastructure development, performance measure management, and quality improvement systems.

SSDI develops and maintains web sites which provide stakeholders the opportunity to seek and offer comments in a public forum. These web sites generate a great deal of discussion which are helpful in implementing new or revised program rules, policies, RFAs, legislative bills, funding opportunities, and new initiatives such as CHIP and Title V federal and state priorities. These electronic interfaces not only reduce Title V staff members' time and effort in copying and mailing materials and answering routine questions but also keep stakeholders abreast of the latest information.

Border Health

The Title V Program has a long history of providing support for MCH and CSHCN services throughout the border region. Table 3 provides a summary of the major categories of contracts awarded in FY 1999 in the border region, which is located in three TDH public health regions (PHRs 8, 9/10 and 11). It is important to note that this is a general summary of contracts only. Many services, including the majority of CSHCN specialty and subspecialty services, are not delivered via contract; instead services are delivered by individual providers enrolled in the program. See table below.

Table 3 FY 1999 MCH and CSHCN Contracts in the Border Area (Public Health Regions 8, 9/10, 11)		
Contract Category	Number of Contracts	Contract Amount
CSHCN case management	6	\$1,091,271
MCH direct & enabling services (family planning, child health, prenatal care, case management, dysplasia)	29	\$2,382,211
MCH population-based and infrastructure-building	11	\$1,303,203
Genetic direct and enabling* (*PHR 1 and PHR 7 contracts serve border region)	2	\$74,167
Genetics population-based and infrastructure-building	1	\$53,282
School-based health centers	5	\$783,113
School health network (regional Education Service Centers)	7	\$191,276
South Texas Women's Center	1	\$853,107
Total	62	\$6,731,630

TDH established the Office of Border Health in 1993 to enhance department-wide efforts to promote and protect the health of border residents by reducing community and environmental health hazards in collaboration with local communities and U.S. and Mexican local, state, and federal entities. The Office has field staff coordinators in El Paso, Uvalde, Laredo and Harlingen, who serve as generalists, working on public health issues that cross program lines, with a special emphasis on critical environmental health issues such as clean drinking water and wastewater treatment.

The Office of Border Health is involved in a number of projects including community sanitation, food and product safety, an environmental health survey, and a geographic information system project to map populations at high risk for pesticide exposure. Two projects directly related to maternal and child health are the tuberculosis elimination project and the neural tube defects project. Title V provides partial funding for the latter.

Emerging Roles of Public Health

TDH is currently examining the roles and responsibilities of its programs and stakeholders in implementing legislative bills that were enacted last session. The passage of bills such as HB 2085 and HB 1444 brought excitement to TDH, on the one hand and, on the other, challenges to overcome. These two bills stipulate the need for integration of functions of Medicaid and non-Medicaid health care delivery programs and the administration of grants to communities for essential public health services. They will facilitate the change in philosophy of TDH in protecting and promoting the health of all Texans. TDH Title V program is gradually shifting its focus away from the traditional medical treatment model toward programs based on theory that individual human well-being depends on the quality of the social, physical, and economic environments in which we live. At the same time, a great deal of effort and resources must be deployed to involve community health leaders, contractors, and consumers in every step of the process.

Through the successful implementation of these two bills, communities will be partners with TDH in enhancing the health of their citizens. Both entities, TDH and the communities, will benefit from an efficient and cost effective integrated service delivery that ensures medical homes for clients and reduces administrative and paperwork burdens on providers.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

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

2.2 Annual Number of Individuals Served

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

2.3 State Summary Profile

See Supporting Documents, Form 10.

2.4 Progress on Annual Performance Measures

The following approach has been used to complete the FY 98 Annual Report. It is divided into two sections: national performance measures and state performance measures. FY 98 was the year Texas participated in piloting the Title V guidance draft. The Annual Plan submitted in July, 1998, included 18 national measures, some of which have been revised or deleted, while others have been added. Additionally, some of state performance measures presented in the FY 98 Annual Plan have been revised better to reflect state priority needs. As a result, this report includes a mixture of old and new performance measures. The numbering system and categorization follow those of the current national performance measures.

2.4.1 National Performance Measures

Direct Health Services: None

Enabling Services: None

Population-Based Services:

04

Type: Risk Factor

Population: Women & Infants

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

Plan of Action

1. Activity: Continue to aggressively case manage identified presumptive positive cases according to program standards and protocols.

Status: Ongoing

Progress Report: The following data show the program maintained its follow-up/case-manage processes to assure treatment for all confirmed cases where treatment was needed:

Types of screening	Number of presumptive positive screens	Number of confirmed cases	Confirmed cases that received treatment
● Congenital hypothyroidism	7,320	155	155
● Congenital adrenal hyperplasia	*	26	26
● Phenylketonuria	583	15	15
● Galactosemia	110	7	7
● Sickle Cell Disease	146	133	133

* Data in this category are not available at the present time.

2. Activity: Ensure that all people who attend the newborn are aware of the legal requirement for newborn screening.

Status: Ongoing

Progress Report: There are no known cases of presumptive positive screens that lacked follow-up.

Number of registered births: 346,216

Number of newborns screened: 332,588

05

Type: Risk Factor

Population: Children

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

Plan of Action

1. Activity: Continue the promotion of "My Child's Health Record" to be distributed statewide to all parents regardless of income.

Status: Ongoing

Progress Report: "My Child's Health Record" continues to be distributed by TDH's Immunization Division. It is sent to providers and other interested parties upon request. In FY97 approximately 500,000 health records were distributed; however, none were sent out in FY98, because the health record was being revised and there was a question as to whether or not it would be published again.

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

Status: Ongoing

Progress Report: By August 1997, ImmTrac, TDH's automated immunization tracking system for group provider use, was installed in every TDH public health regional administration office and sub-offices. During FY98, the system was expanded to the following entities serving children: 58 local health departments across Texas; 1 day-care center, 6 public school districts; 2 private hospitals; 2 university campuses; 3 private doctor offices. All these entities generated a total of approximately 240 workstations installed with ImmTrac. *[These data were mistakenly reported as FY97 data last year. Except for TDH regional installations, the activities generating these data occurred during FY98.]*

These sites may submit WIC, Texas Health Steps, Medicaid, Integrated Client Eligibility System, and private-pay immunization data through the ImmTrac system. The system has limited security, i.e., it may be read only or users may be able to add information on line, depending on each site's needs and security level. Additionally, the ImmTrac system receives data from 2,775 public and private provider sites across Texas that do not have ImmTrac installed onsite and, therefore, must submit reports electronically via their own data-processing systems.

Baseline Immunizations Data

Proportion of Children, Ages 19-35 Months, Completing Immunizations: Texas, 1995-97

Specified Year	4:3:1:3 Series*	3 Hepatitis B**
YEAR 2000 GOAL	90%	90%
1/95 - 12/95 ¹	73%	No #s for '95
1/96 - 12/96 ²	72%	82%
1/97 - 12/97 ³	74%	82%
7/97 - 6/98 ⁴	75%	No goal set

* Four or more doses of diphtheria and tetanus toxoids and pertussive vaccine/Diphtheria and tetanus toxoids (DTP/DT), three or more doses of poliovirus vaccine, one or more doses of measles-mumps-rubella containing vaccine (MCV), and three or more doses of Haemophilus influenzae type b vaccine (Hib).

** Data from selected urban areas — Bexar, Dallas, and El Paso Counties and Houston

¹ MMWR Vol. 46, No. 8, 02/28/1997

² MMWR Vol. 46, No. 29, 07/25/1997

³ MMWR Vol. 47, No. 24, 07/10/1998

⁴ July 1997- June 1998 (unpublished data received by TDH)

While Texas did not achieve the 1996 Childhood Immunization Initiative goals for three or more doses of DTP/DT, three or more doses of polio virus vaccine, one or more doses of MCV, or three or more doses of Hib; the State did achieve its 1996 goal for three or more doses of hepatitis B vaccine in the targeted urban areas.

06**Type:** Risk Factor

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

Population: Children**Plan of Action**

1. Activity: Implement the abstinence-only education program targeting adolescents; provide family planning clinical and educational services to adolescents statewide through the approximately 130 agencies which contract with TDH. Evaluate the benefits and feasibility of developing a media campaign intended to reduce the incidence of teen pregnancy and make recommendations to executive administration.

Status: OngoingProgress Report:

- The Abstinence-Only Program issued a statewide Request for Proposals to provide funds for abstinence education to communities through grants. In FY98, 21 applicants received awards and 6,138 teens were served through that program. (Since contracts only began in February 1998, these figures are from the last two quarters of the state fiscal year.)
- Additionally, Family Planning clinical and/or educational services were delivered by TDH contractors using Title V, Title X, Title XIX, and Title XX funds.

In FY98 an estimated 47,299 CSHCN clients were served by regional staffs and 14,814, by the 21 contractors. Initial discussions regarding the development of a teen pregnancy prevention media campaign with Family Planning and Abstinence-Only Program collaboration were discontinued due to other demands on staff time and resources. It was determined that a media campaign was not a realistic project at that time.

Data are not in a consistent format across funding sources. Numbers of teens served by TDH contractors and TDH PHR clinics (the latter reported via ICES) in FY98 were as follows:

Title V	— 6,058 clients, ages 13-17 years
Title X	— 2,736 clients, ages 15-17 years (between 12/1/97 - 11/30/98)
Title XIX	— 20,703 clients, ages 15-17 years
Title XX	— 50,017 clients, ages 15-19
	— 36,126 clients, ages 19 and younger, who received group counseling

2. Activity: Monitor implementation of the IT TAKES TWO adolescent pregnancy prevention program by trained presentation teams in four communities and determine if statewide replication of the program is feasible by August 31, 1997.

Status: Completed in FY97 and discontinued

Progress Report: In FY97, two teams successfully integrated IT TAKES TWO into their community education programs; its message was well-received by those local schools and other audiences. [IT TAKES TWO is an innovative educational program that encourages

young men and women (ages 12-19) to see pregnancy prevention as a shared responsibility by illustrating the consequences of premature and unprotected sexual activity, motivating them to make responsible decisions about sex, and modeling healthy, respectful, and safe male/female relationships.] The two teams continued to use the curriculum. Two other teams were unable to implement the curriculum due to staff losses and to the requirement that all presenters be trained by IT TAKES TWO staff. Interested groups or individuals are referred to the IT TAKES TWO Program staff in Iowa for information, but costs of repeated training to maintain sufficient presenters throughout the state resulted in a decision not to replicate the program on a statewide basis.

3. Activity: Update the Texas Teen Pregnancy Fact Sheet and distribute statewide by August 31, 1997.

Status: Completed

Progress Report: County and state teen pregnancy fact sheets were updated in FY98 and distributed upon request. In addition, 50,000 copies of an updated state teen pregnancy fact sheet were printed in color and distributed for use by schools and community groups in FY98. These fact sheets graphically portrayed birth rates by county and by ethnic/racial distribution. They informed the reader about family planning services in Texas, birth outcome indicators, prevention strategies, and timed occurrences of teenage conception at each age level (13-17). An example of the FY98 fact sheet is in Appendix H..

Infrastructure-Building Services:

<p>11 Type: Capacity Population: CSHCN</p>	<p>Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.</p>
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Plan of Action

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

Status: Ongoing

Progress Report: As of April 30, 1999, the Chronically Ill and Disabled Children's Program (CIDC) paid medical claims to 6,348 CSHCN. Of those, 568 also had Medicaid coverage and 981 had other insurance. Case management services provided by 21 contractors and by TDH regional staffs enabled linkage and access to primary and specialty care through a variety of state and federal funding sources, including insurance programs. In FY98 an estimated 47,299 CSHCN clients were served by regional staffs and 14,814, by the 21 contractors. Part of that case management role is to assist clients in applying to the various funding/insurance programs and to make referrals to appropriate programs as indicated by a client's circumstances.

2. Activity: Continue to refer CIDC clients who meet guidelines to Medicaid/Medically Needy Program (MNP).

Status: Ongoing

Progress Report: TDH regional staffs and the 21 contractors help clients make application to the Medicaid/MNP, and staff make referrals to these programs as indicated by individual needs and issues.

Fiscal Year	Referrals made to Medicaid/MNP	Clients Enrolled in MNP	Clients Receiving Medicaid coverage
FY97	6,351	1,028	986
FY98	5,494	711	815

TDH, Bureau of Children's Health, CIDC Program Data Base, 7/99

Analysis: There has been a decrease in the number of clients sent to and enrolled in Medicaid/MNP. The decrease appears to be associated with TDH's mandatory requirement that CIDC clients to apply to Medicaid and to the MNP.

12

Type: Capacity

~~**Population:** Children~~ ~~Percent of children without health insurance.~~

Plan of Action

1. Activity: Maintain and expand the scope of the pilot program in Laredo to provide primary care health insurance coverage to about 400 children under 13 years of age who do not qualify for Medicaid, as mandated by the Texas Legislature through passage of Rider 55 in FY97.

Status: Ongoing

Progress Report: House Bill 997 (74th Regular Session, Texas Legislature) required TDH to establish a pilot project to provide primary care health insurance coverage for children younger than 13 years of age who are ineligible for Medicaid. TDH was authorized to make the program available through local public schools, to use the Florida Healthy Kids program as a model, and to collect co-pays and sliding scale premiums. The pilot project was implemented in Laredo at Farias Elementary School. Through a competitive bidding process, a health insurance plan was selected that provides children with comprehensive benefits at an affordable cost — \$45 per month — and with access to a local network of health care professionals and hospitals.

The pilot was initially funded with TDH Title V funds. After the project began, public and private entities expressed the desire to participate by donating funds. Their contributions brought the total enrollment to 389 children. Of those, 40 were in the sliding scale fee program, with 23 at 134-200% FPL and 17 at 201-250% FPL.

2. Activity: Assist the Texas Healthy Kids Corporation Board of Directors in developing a statewide health benefits program for primary and preventive health care for children who are uninsured, as required by the passage of HB 3 in FY 97.

Status: Ongoing

Progress Report: In FY98 the Board for Texas Healthy Kids worked to develop a program of statewide health benefits to uninsured children. CSHCN staff were available to the Board at that time but were not asked to contribute to the program's development. It was anticipated that CSHCN staff would become involved after implementation of the Texas Healthy Kids program in FY99.

3. Activity: Assist in the development and evaluation of RFAs for the expansion of Medicaid managed care models for three county service areas (Harris, Dallas, and El Paso) by August 31, 1997.

Status: Ongoing

Progress Report: Texas continues to roll out its Medicaid managed care program. As of August 1 1998, there were 602,752 participants in managed care. Of those, 64% were in health care maintenance organizations and 36% were in primary care case management arrangements. Title V staff assisted the Bureau of Managed Care in developing and implementing a process and forms for contract monitoring and evaluation. Texas now has Medicaid managed care in the following county/service areas:

Service Area	Counties Served	No. of Contracts
Travis County Service Area — Austin	Travis, Burnet, Blanco, Hays, Caldwell, Bastrop, Lee, Williamson, and Fayette	3
Bexar County Service Area — San Antonio	Bexar, Kendall, Comal, Medina, Atascosa, Wilson, and Guadalupe	4
Tarrant County Service Area — Fort Worth	Tarrant, Wise, Denton, Parker, Hood, and Johnson	4
Lubbock County Service Area — Lubbock	Lubbock, Lamb, Hale, Floyd, Crosby, Garza, Lynn, Terry and Hockley	3
Southeast Region Service Area — Beaumont	Chambers, Jefferson, Liberty, Hardin and Orange	1
Harris County Service Area — Houston	Harris, Fort Bend, Montgomery, Waller, Brazoria and Galveston	7

Managed care will be rolled out in FY99 in the Dallas Service Area (Dallas, Ellis, Kaufman, Rockwall, Hunt, Collin and Navarro Counties) and in FY00 managed care is expected to expand to serve El Paso Service Area (El Paso, Hudspeth and Culberson Counties).

13**Type:** Process**Population:** Children

Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Plan of Action

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

Status: Ongoing

Progress Report: In FY98, 1,537,180 children were potentially eligible for Medicaid. Of those, 722,972 (47%) received a service paid by Medicaid program.

15**Type:** Risk Factor**Population:** Women & Infants

Percent of very low birth weight live births.

Plan of Action

1. **Activity:** Pre-pregnancy planning provides the best opportunity for positively affecting pregnancy outcomes, including reduction of VLBW live births. The next window of opportunity needs to occur by 16-18 weeks of pregnancy. TDH will reactivate its prenatal care awareness campaign targeting pre-pregnancy counseling and early prenatal care. This will include distributing promotional/educational materials such as PSAs and written materials to Title V maternity contractors, WIC clinics, family planning clinics and consumers. We also need to identify factors which cannot be influenced by TDH.

Status: Ongoing

Progress Report: Regional and central office staffs focused on providing reproductive-aged women in Texas with an awareness of the benefits of pre-pregnancy counseling and first-trimester prenatal care. Although the prenatal care awareness campaign was temporarily put on hold, primary elements of prenatal care awareness were successfully disseminated to the public.

Current data (1997) reveal that out of 333,829 live births in Texas, 4,436 had very low birth weight (1.3% of all births to Texas women). Women of African-American ethnicity, women ages 14 years and younger, and women 40 years and older are at highest risk for VLBW live births.

16**Type:** Risk Factor**Population:** Children

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

Plan of Action

1. Activity: Develop a plan for reducing teen suicide deaths in cooperation with the Texas Department of Mental Health and Mental Retardation (TXMHMR). The Texas 75th legislature enacted a law providing for a State suicide prevention officer who will be located at TXMHMR. Title V Adolescent Program staff will work in close contact with the office and with the Mental Health Association of Texas. A brochure and video targeting adolescents will be piloted in six Title V contract sites with post viewing evaluation tools for both adolescents (knowledge and attitudes) and provider (opinion about appropriateness of content). Pending results of the evaluation, statewide distribution of these materials is planned.

Status: Ongoing

Progress Report: Adolescent Health Program staff initiated a contract for authority to reproduce unlimited copies of the videotaped curriculum entitled "Mental Health CPR," produced by Dr. Phil Caterbone, M.D. "Mental Health CPR" is a 20-minute videotaped curriculum modeled after the medical community's Cardio-Pulmonary Resuscitation (CPR) program. It helps youth to identify the signs and symptoms of a peer who may be contemplating suicide and promotes interventions a young person can take to prevent a peer's suicide: (1) recognizing suicidal symptoms; (2) obtaining a basic No Harm Agreement (NHA); and (3) arranging for professional intervention.

The video was piloted and a pre- and post-viewing questionnaire was developed (accompanied by a parental consent form) to assess the video and its effectiveness in eliciting the desired behaviors. Twelve Texas schools participated in the pilot study for a total of 840 students from grades six to twelve (ages ranged from 11 to 20 years old, with a mean age of 15.3 years). Statistically significant changes in knowledge and skills of peer suicide intervention occurred for students who viewed the video, revealing an intent to help prevent peer suicide and to call 911 if a friend threatened to commit suicide.

As a result of these positive findings, plans are under way to incorporate the "Mental Health CPR" training into the Adolescent Health Program through cooperation with the Texas Education Agency.

17

Type: Risk Factor

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

Population: Women & Infants

Plan of Action

1. Activity: Conduct a project to identify the key reasons why the percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates is decreasing, and develop a plan for maintaining and improving the service system that focuses on changes in: Medicaid, hospitals and perinatologists.

Status: Completed

Progress Report: It was thought when this activity was written (before FY97 data were collected) that the percentage of VLBW infants delivered at facilities for high-risk deliveries

and neonates was decreasing; however, FY97 data showed an increase in the percentage deliveries from 51.5% in FY94 to 53.5% in FY97. The need to gain a better understanding of the existing service delivery system seems apparent from the discrepancy in the believed status of service delivery in FY98 and the actual reported condition.

An advisory committee consisting of neonatologists, obstetrician/perinatologists, an HMO medical director, administrators of several hospital districts, a private obstetrician, and a chair of a medical school obstetric department was convened to develop a plan to identify factors associated with very low birth weight deliveries. This group met twice during FY97 and also advised on the design of rules to establish standards for a delivery system. They reviewed and commented on several drafts of rules, which, in addition, were distributed for comment to over 100 hospital districts and to the chairs of the departments of pediatrics, obstetrics, and family planning at each Texas medical school. Conference calls were held with TDH regional directors to involve them in the design of their participation in the perinatal care system.

2. Activity: Develop standards and objectives for the establishment of a statewide network of voluntary perinatal health care systems, as directed by Texas House Bill 2212, by August 31, 1997.

Status: Ongoing

Progress Report: In FY98, the Texas Commissioner of Health requested a revision of rules being proposed to the Board of Health. Staff were asked to redefine the perinatal health care system so that it reflected a broader perspective of community-based support and service delivery. This revision was postponed due to the retirement of the staff person responsible for drafting the rules. Work resumed on the rules revision in the summer of 1998.

Data from 1997 (the most current) show that there were 4,436 VLBW births to residents in Texas. Of those, 2,354 VLBW births (53.1%) occurred in facilities for high-risk deliveries and neonates.

18

Type: Risk Factor

Percent of infants born to pregnant women receiving

Population: Women & Infants

prenatal care beginning in the first trimester.

Plan of Action

1. Activity: Pre-pregnancy planning provides the best opportunity for positively affecting pregnancy outcomes. The next window of opportunity needs to occur by 16-18 weeks of pregnancy. TDH will reactivate its prenatal care awareness campaign targeting pre-pregnancy counseling and early prenatal care. This will include distributing promotional/educational materials such as PSAs and written materials to Title V maternity contractors, WIC clinics, family planning clinics and consumers.

Status: Ongoing

Progress Report: The prenatal care awareness campaign was not implemented during FY98 due to changes in central office staff who had planned and would have implemented the campaign. As a result of those changes, regional personnel distributed existing

promotional and educational materials to providers, emphasizing pre-pregnancy counseling and early entry into prenatal care. Additionally, WIC clinics, family planning clinics, and Title V maternity contractors provided timely and appropriate health education to clients and friends of clients visiting their clinics.

There is still need for a prenatal care awareness campaign, as indicated by the regional and ethnic/racial data reported below. More current data will be reviewed, and a plan will be developed to target a prenatal care awareness campaign toward areas of the state and ethnic/racial populations with lowest rates of entry into first-trimester prenatal care.

2. Activity: Continue the Texas Neural Tube Defects (NTD) Project — to include active surveillance, folic intervention, and a case-control study — in 14 counties along the Texas-Mexico border.

Status: Ongoing

Progress Report: TDH staff identify NTD-affected pregnancies of residents in the 14 Texas-Mexico border counties. In order to decrease the risk of NTD recurrence, education and folic acid supplementation are provided to those women with NTD-affected pregnancies and to those at risk due to a prior NTD-affected pregnancy. TDH staff are also conducting a case-control research study to identify NTD risk factors in an attempt to decrease the number of NTDs in Texas.

The border community asked TDH staff to determine whether environmental contaminants caused the NTDs in question. The question, which generated international attention and news coverage, is the focus of the case-control study. The NTD intervention with folic acid is a nationally recognized model state program for prevention in a high-risk population. Local project personnel enable families to “move on” and to have subsequent healthy babies as a result of the project’s education campaign and folic acid supplements. The collaborative nature of the project leverages the resources of many state medical schools and federal agencies to get the “biggest bang for the buck.”

Community outcomes between 1993 and 1997 were:

- 301 women with NTD-affected babies (13.4 per 10,000 live births)
- 227 eligible for folic acid intervention
- 138 currently enrolled in project’s activities
- 98 subsequent pregnancies
- 1 recurrent NTD occurred in a non-participant (4-5 expected)
- 89/92 eligible case-women are participating
- 107/139 eligible control-women are participating

Births to Women Receiving 1st-Trimester Prenatal Care

Fiscal Year	Births	Percent with 1st-Trimester Care
1996	330,238	78.1%
1997	333,829	78.5%

Areas in Texas with low percentages of first entry into prenatal care have been identified geographically and by ethnicity/race.

Geographic Areas of Lowest First-trimester Entry Rates*

Public Health Region	Percent with 1 st -Trimester Care
9	74.8%
10	65.7%
11	68.3%

*Two of these regions with the lowest total rates appear to have high first-trimester entry numbers in metropolitan counties or within close proximity — PHR 9 at 80.3% entry in Midland County and PHR 11 at 81.9%, for Nueces County.

First-Trimester Entry into Prenatal Care by Ethnicity/Race, FY97

Ethnicity/Race	White	Black	Hispanic
Percent 1 st -Trimester Care	86.7%	74.6%	71.2%

AA

Type: Risk Factor

Population: Children

The incidence of youths 15-19 years old who have contracted selected sexually transmitted diseases (STDs).

Plan of Action

1. Activity: Increase the number of adolescents who receive regular preventive health care, with STD screening as appropriate. Ensure compliance and effectiveness of treatment and counseling after diagnosis of STDs. Ensure TDH formularies meet current CDC guidelines. Continue coordination with the TDH HIV/STD program to prevent duplication and increase efficiency.

Status: Ongoing

Progress Report: The Adolescent Health Promotion Program developed a two-pronged plan to increase the number of adolescents receiving regular preventive health care with STD screening as appropriate. The plan proposes: (1) to provide statewide training to Texas Health Steps (THSteps) outreach workers on how to increase adolescent enrollment in the THSteps program — the state's Medicaid program and (2) to enlist the services of the Texas Nurses Association to offer training to registered nurses, nurse practitioners, and physician assistants on assessing the health needs of adolescents through comprehensive health visits that include STD screening for sexually active teens or for those over age 18.

THSteps increased its adolescent participation rate for ages 6-14 from 55% in FY97 to 61% in FY98. The rate for the 15-20 age group increased from 24% in FY97 to 33% in

FY98, a 9% increase. These numbers do not include all check-ups completed in the capitated managed care system.

Twenty-five percent of one FTE in the Family Planning Program (FP) is dedicated to participation in the federal Region VI Infertility Prevention Project (IPP), a collaborative effort between FP, the STD/HIV Program, and the Public Health Laboratory serving Texas, Arkansas, Louisiana, New Mexico, and Oklahoma. IPP's purpose is to reduce the prevalence of *Chlamydia trachomatis* (Ct) infections and their sequelae (one of which is infertility) through screening, treatment, and follow-up services.

Duplication of effort is not seen as a problem, since TDH's FP and STD clinics generally provide services to different sets of clients (asymptomatic versus symptomatic respectively). The primary target population for the IPP is 15- to 19-year-old young women, with the 20- to 25-year-old group being secondary. These age groups accounted for 76% of the chlamydia cases reported and treated in 1998. If their partners test positive, they may be treated as well.

The STD/HIV Bureau of TDH adheres to the CDC Treatment Guidelines and has a Division of Pharmacy which is responsible for any formulary needed.

Baseline STD Data

STD Cases and Rates for Adolescents Ages 15 to 19 Year-Olds, Texas — 1998

Diagnosis	Cases	Rate*
Chlamydia	24,327.0	1,620.4
Gonorrhea	10,385.0	691.7
Syphilis	48.0	3.2
Total	34,760.0	2,315.3

* Rate per 100,000 persons aged 15-19

— TDH, Bureau of HIV/STD, Bacterial STD reports for CY 1998

Between FY97 and FY98, the numbers of cases and rates of STD cases increased across every diagnosis except "Syphilis"; the number of cases and rates for "Syphilis" were remarkably lower in FY98. No attribution can be offered as to probable cause for these changes in the data; however, the increases and the one decrease in number and rate of cases is parallel across number and rate, which occurrence discounts the possibility that overall Texas population growth is affecting the increases in numbers.

BB

Type: Process

Population: Women & Children

The State Title V program has adopted and recommended a set of quality standards for the health care of the MCH population.

Plan of Action

1. Activity: Conduct risk assessments on all Title V contractors once a year and provide immediate on-site monitoring visits to those who are most at risk of failing to meet program standards.

Status: Ongoing

Progress Report: Risk assessments occur every November for all Title V contractors. During FY98, 20 out of 93 fee-for-service contractors were identified as being at greatest risk for failing to meet program standards. Forty-two Title V contractor site visits were conducted in that year. Whenever there are site visits with a fee-for-service contractor who also has a population-based contract, the latter project will be inspected whether or not they are at risk. (Not all Title V contractors have both fee-for-service and population-based projects.)

The 32 population-based contractors are also assessed for risk in November. Since they are pilot projects with diverse goals and activities, the analysis of whether they meet standards primarily focuses on contract-related issues. Standards for program content and process may not be appropriate until such time as there is greater uniformity in the local issues addressed by each contractor.

2. Activity: Provide on-site monitoring visits to all Title V contractors every two-year cycle.

Status: Ongoing

Progress Report: Forty-two Title V contractor site-monitoring visits were conducted during FY98. All monitoring visits required corrective actions. Additionally, Regional staffs conducted 38 follow-up visits in FY98 to further assure compliance with TDH standards. The following are common findings needing remedy across the state: incomplete documentation, quality assurance system not in place, protocols not in place, and standing delegation orders not in place to authorize triage responsibilities for unlicensed or licensed staff who routinely do not perform that function.

2.4.2 State Performance Measures

Direct Health Services:

<p>01 Type: Process Population: Women & Children</p>	<p>Increase the number of Title V clients who receive one of the most effective methods of birth control (female sterilization, vasectomy, injectable contraceptive, implant, IUD).</p>
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Plan of Action

1. Activity: Promote the reliability, efficacy, and cost-effectiveness of the contraceptive methods (female sterilization, vasectomy, injectable contraceptive, implant, IUD) through education and outreach to clients.

Status: Ongoing

Progress Report: This activity was only partially undertaken. Most of the 61,166 Title V family planning clients in FY98 received health education while attending clinic, and all had

access to the comprehensive literature on contraceptive methods that was readily available in the clinics. Title V contractors served 57,779 of those clients and TDH regional staffs served 3,387.

2. Activity: Work in collaboration with Title V clinic staff to recruit and/or train providers regarding the most effective contraceptive methods where barriers exist because providers are unable or unwilling to offer the method.

Status: Not completed, not ongoing

Progress Report: This activity was not undertaken. Constraints placed on contractor agencies by reductions in family planning dollars from two federal funding streams hampered the agencies' ability to purchase sufficient supplies of the most effective birth control methods to meet an increased need. (The most effective birth control methods are also the most expensive.)

02

Type: Risk factor

Increase the utilization of genetic services by school-

Population: Children

age children.

Plan of Action

1. Activity: Mailing to school special education directors and to the School Health Network (includes regional Education Service Center school health specialists and TDH school health projects) and to other health providers of a Fact Sheet and simple screening tool for assessment of children with learning difficulties in order to determine if genetic evaluation is indicated.

Status: Completed

Progress Report: 1,132 packets were sent, including a video on "Indicators for a Genetic Referral," a 57-item checklist in English and Spanish to help determine when a child needs genetic services, and facts about genetics. 491 children from 3-17 years old were referred for genetic services (Appendix I).

2. Activity: Plan presentations/exhibits at annual School Health Network and other meetings.

Status: Completed

Progress Report: 12 presentations/exhibits were held in the following locations — the number of participants at each are listed in parentheses: Austin (50), Corpus Christi (30), Houston (50), Austin (30), Arlington (50), Fort Worth (75), Austin (30), Galveston (30), Austin (30), San Antonio (20), Austin (50). At each site videos, checklists, 10 varied handouts/brochures, and three different posters were provided to participants. 491 children from 3-17 years old were referred for genetic services.

3. Activity: Post a notice that includes the screening tool and a Fact Sheet to the Healthy Texans Bulletin Board System MCH Library of resources.

Status: Ongoing

Progress Report: A checklist of 57 items to indicate the need for genetic services and facts about genetics were developed, but final approval for posting on system has not yet been obtained. The materials are scheduled to be re-evaluated, based on early results from Activities 1 and 2 above.

03	Increase the proportion of children who have received protective dental sealants on the chewing surfaces of permanent molar teeth.
Type: Risk Factor	
Population: Children	

Plan of Action

1. Activity: Collaborate with Texas dental schools to establish a continuing education program on sealants procedures for dentists and hygienists.

Status: Ongoing

Progress Report:

- Continuing education programs about sealant procedures are provided for dentists and hygienists through the three Texas dental schools.
- The National Heritage Insurance Company (NHIC), the insurer of the Texas Medicaid program, sponsors annual oral health services workshops, which include sealant placement training, for Medicaid dental providers in all TDH public health regions.
- In order to increase the provider base for Medicaid dental providers, the Division of Oral Health's State Dental Director and NHIC conduct seminars about the Texas Health Steps services program (formerly EPSDT) for dental school senior students.

2. Activity: Implement a statewide parent/child sealant awareness campaign to improve the knowledge regarding sealant placement.

Status: Ongoing

Progress Report: The Take Time for Teeth (TTFT) initiative was established to present a singular message about oral health to Texans across the state. In FY98, TTFT's major accomplishment was the production and implementation of a comprehensive oral health promotion training module, developed by the Oral Health Standardized Promotion and Implementation Team (central office and regional staff from diverse areas of expertise). The training objectives are: (1) to develop a consistent, standardized oral health message for clients, (2) to develop partnerships/collaborations to expand outreach, and (3) to educate clients at an earlier age about the importance of preventive oral health practices.

The module, provided to both the private and the public sectors, includes a trainer's manual, a workbook for trainees, and a training video and brochure for clients. The video

and brochure are available in English, Vietnamese, and Spanish. All TTFT training materials carry consistent information about the importance of dental checkups for pregnant women, the recognition of “white spots” and how to prevent baby bottle tooth decay, the benefits of taking your child to the dentist every six months beginning at one year of age, and the importance of dental sealants in preventing tooth decay.

In order to increase manpower capabilities and to expand outreach potential, TDH regional dental staff conducted train-the-trainer workshops for TDH Volunteers in Service to America (VISTA) participants, Texas Health Steps (THSteps) outreach workers, and workers at local agencies such as WIC and Head Start programs.

3. Activity: Promote the utilization of sealant placement among families and providers in the Medicaid/THSteps program.

Status: Ongoing

Progress Report:

- Training sessions were provided to TDH VISTA participants, to THSteps outreach workers, and to workers at local agencies such as WIC and Head Start programs. To date, more than 1,700 participants have been trained from the public and private sectors around the state; they are educating families and providers about the importance of oral health practices, including sealant placements.
- The Statewide School Screening and Sealant Initiative promotes the utilization of sealants by providing dental sealant services to children on the free lunch program within the Texas public school system.
- Information about access to dental services, including sealant placements, is provided through the BabyLove Hot Line and through TTFT oral health training sessions.

Enabling Services:

04

Type: Process

Population: Women & Infants

Promote the use of pregnant women and infants case management as part of the THSteps case management marketing strategy by mailing educational and informational materials for Title V providers.

Plan of Action

1. Activity: Notify all Title V prenatal care contractors and providers of similar services that pregnant women and infants’ case management services are available.

Status: Completed

Progress Report: The following data show this activity increased the total number of unduplicated clients served through Title V Case Management services.

Total Unduplicated Clients Served:	50,559
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Total Pregnant Women Served:	46,641
▶ At TDH clinics	540 *
▶ By Title V contractors	46,101
 Total Infants Served:	 3,918
▶ At TDH clinics	94 *
▶ By TV contractors	3,824

* The great variation in the number of clients served in TDH clinics and those served by contractors has to do with the fact that direct services in the public health regions, or the TDH clinics, were greatly curtailed in an effort to shift funding from direct to population-based and infrastructure-building services. The decision to transition funding toward population-based/infrastructure-building services arose out of the 1996 Title V Futures planning and resulted in 32 contractors receiving population-based/infrastructure-building fund for a three-year period beginning in FY97.

Population-Based Services:

05	Institute neonatal hearing screening, with referral to confirmatory testing, in birthing hospitals of at least 1/3 of Texas newborns.
Type: Process	
Population: Infants	

Plan of Action

1. Activity: Explore opportunities for funding to expand the current hearing screening capacity; provide training through contractors to interested birthing hospitals; and loan testing equipment as available.

Status: Ongoing

Progress Report: In FY98, 41,937 newborns were screened. The overall referral rate after a newborn failed two screens in the hospital was 3.5%; this rate includes hearing loss that could be transient. During FY98, one false negative test was identified by the Sounds of Texas implementation team, a group of professionals who provide consultation and evaluation skills to the project. (Data collection from the increased screening efforts will reveal which children passed neonatal screening and were later shown to have hearing loss. That is not necessarily a false negative finding, since there may be conditions that have a late impact rather than presenting at birth.) The Sounds of Texas team is expected to offer consultation and assessment services to project-trained hospital staffs in order to establish and certify effective newborn hearing screening programs and to facilitate re-certification of those programs.

In FY 98 TDH planned to ask the Texas Legislature for funding to expand Medicaid services to include a newborn hearing screen.

Infrastructure Building Services:

06	Population: Children
Type: Capacity	

Develop and implement a methodology and survey tool to measure child and adolescent obesity rates in Texas.

Plan of Action

1. Activity: Design and pilot methods/survey tools to collect height/weight data and other information (e.g., eating behavior, physical activities) on children and adolescents in schools and Title V/WIC clinics.

Status: Ongoing

Progress Report: The School-Based Nutrition Monitoring Survey was developed and tested for reliability and validity by the nutrition faculty at the University of Texas (UT) School of Public Health. This monitoring system includes surveys of students in 4th, 8th, and 11th grades to determine their knowledge, attitudes, and behaviors related to nutrition and physical activity. Heights and weights of the students will also be obtained. The monitoring system also includes surveys to assess: (1) school food service progress toward offering school meals that meet the Dietary Guidelines and (2) school nutrition education activities. TDH central office staff nutritionists met three times with UT School of Public Health nutrition faculty to discuss how a randomized sampling survey of 4th, 8th, and 11th graders could be conducted. A plan was written and submitted to the Title V director in an attempt to fund a contract with the UT School of Public Health to develop the survey Scantron forms for data collection, to conduct data analysis, and to prepare reports. Although the Title V Director was supportive of this activity, there were insufficient funds to direct toward implementation of the school-based nutrition monitoring survey. Staff nutritionists with the central office Division of Health Nutrition and Education will be exploring options for funding and resources needed to accomplish this plan.

07

Type: Capacity

Population: Infants

Develop and implement a measurement tool to assess the impact of nutrition assessment/counseling on the growth and other nutritional status parameters of premature and/or low birth weight infants.

Plan of Action

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

Status: Ongoing

Progress Report: A part-time CSHCN nutrition consultant in the Bureau of Nutrition Services attended training on neonatal nutrition at the Medical University of South Carolina. She reviewed the literature on nutrition care of premature and/or low birth weight infants. The development of the curriculum was delayed, because this nutritionist's time was assigned to immediate priority tasks of WIC, the program through which she is funded. This project will be dropped from the Title V state objectives next year, although staff plan

to develop such a workshop in the relatively near future.

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

Status: Ongoing

Progress Report: This activity will be implemented once a training curriculum for licensed and registered dietitians on nutrition care of premature and/or LBW infants is completed and workshops are conducted.

Progress on Performance Measures

The following is a rough assessment of the status of FY 98 annual performance objectives. Because of significant factors beyond the control of Texas Title V program and the difficulty in proving cause and effect relationships in these settings, it is premature to link any increase or decrease in measurement with the activity plans' completion.

In spite of the efforts made to continue aggressive case management of identified presumptive positive cases and to increase parents' awareness of the legal requirement for newborn screening, the FY 98 performance objective of 96.8% has not been reached. The annual performance indicator shows that 96.1% of newborns in the state receive at least one screening for each PKU, hypothyroidism, galactosemia, and hemoglobinopathies.

Data show that 75% of children through age two have completed immunization shots, which satisfies the FY 98 performance objective. The promotion of "My Child's Health Record" may have helped in achieving the FY 98 performance objective.

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

Data show that the FY 98 performance objective of 17% for third grade children receiving sealants has been achieved. However, it should be noted that data are limited because the denominator includes only children in the Free Lunch program.

Efforts made by CSHCN program regional case managers and contractors to assist CSHCN enrolled in the state program in obtaining a source of insurance have been successful. The FY 98 performance indicator shows that 72% of CSHCN have a source of insurance for primary and specialty care, exceeding the performance objective of 70%.

The FY 98 performance objective of 24% of children without health insurance has not been

achieved. With the implementation of SCHIP in FY 00 and beyond, data will show a major increase in the number of insured children.

In FY 98, 1,537,180 children were potentially eligible for Medicaid. Of those, 722,972 (47%) received a service paid by Medicaid program. The FY 98 performance objective shows a target of 47%.

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

Many efforts are needed in pre-pregnancy planning to provide the best opportunity for positively affecting pregnancy outcomes, including reduction of VLBW live births and in identifying the key reasons why the percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates is decreasing. Neither performance objective for the percent of VLBW and the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates, 1% and 55%, respectively, has not been achieved.

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester still remains a challenge for Texas. While the FY 98 performance indicator shows that 77.8% of this population receive prenatal care in the first trimester, the corresponding performance objective's target is set at 80%.

The educational activities and outreach efforts provided by Genetics Division staff have led to an increase in the performance indicator utilization rate from 22.4 in FY 97 to 28.3 in FY 98. This exceeds the FY 98 performance objective's target of 25.

2.5 Progress on Outcome Measures

Texas is making steady progress in reducing neonatal, perinatal, postneonatal, and infant mortality rates, as well as the overall child death rate. See Supporting Documents, Form 12, for trend data for 1996-2001. In estimates of its FY98 data, Texas exceeds most of the *Healthy People 2000* Objectives for these outcome measures. However, the state's indicators are larger than those of the national objectives in the ratio of black-to-white infant mortality rates, even though the Texas infant mortality rates for blacks and for whites exceed the national objectives. The Texas Title V program is making good-faith efforts to meet this objective by 2000; Texas projections show continued decreases in the black and white infant mortality rates, but the ratio is still predicted to be slightly larger than the *Healthy People 2000* Objective.

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

first-trimester prenatal care.

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

public In 1995 the Texas Legislature mandated implementation of a statewide prenatal care awareness campaign designed to impact the neonatal, perinatal, postneonatal, and infant mortality rates through passage of Rider 45 of the 1996-197 Appropriations Act. Despite being temporarily put on hold due to staffing changes, aims of the awareness campaign were furthered by certain strategies: (1) regional and central office staffs promoted the benefits of pre-pregnancy counseling and first-trimester prenatal care through public dissemination of information on the topics, and (2) WIC, family planning, and maternal and child health clinics continued to provide timely and appropriate health education to clients and visitors. There is still a need for a prenatal care awareness campaign that targets high-risk clients (e.g., African-American, very young, and older women of child-bearing age) and providers who serve those populations. As TDH women's health care staffing stabilizes, this plan will be reactivated along with emphasis on individualized client education to improve birth outcomes.

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

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

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

care was affordable at \$45 per month, and the project provided access to a local network of health care professionals and hospitals.

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

Other efforts to reduce deaths from the neonatal period through early childhood include Texas' implementation of universal HIV screening of pregnant women, with follow-up procedure of administering AZT for positives. Also, case management of 100% of the presumptive positives found by the Newborn Screening Program assures linkage with appropriate care.

Additionally, since January 1995, childhood immunization rates for the 4:3:1:3 series continue to improve by at least one percent every year, thereby reducing the likelihood of childhood mortality to complications associated with diseases like pertussis, diphtheria, polio, and influenza. Hepatitis B immunizations in the four model urban areas — Bexar, Dallas, and El Paso Counties, and Houston — have been maintained at 82%, contributing to lowered child mortality rates in areas where Hepatitis B is more likely to be transmitted on a widespread scale. Although the costliness of these immunizations prohibits their statewide administration at the present time, expanded service areas will greatly improve state childhood mortality outcomes resulting from loss of liver function.

Piloting a video on teenage responsibility for personal actions, "Mental Health CPR," and collecting/analyzing data from the pilots were among the first steps taken to address the teen suicide rate in Texas. Like the work needed to reduce all childhood mortality, teenage suicide requires multiple, interdisciplinary, and cross-agency approaches to intervention in order to assure the desired outcomes of greatly reducing or even eliminating teen suicide. TDH's hiring of an adolescent health coordinator in September 1996 is facilitating program development along those lines.

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

During FY98 TDH staff distributed 10,895 bicycle helmets to 104 community programs,

provided free education on the proper use of bicycle helmets, conducted 15 training programs, and coordinated 12 community bicycle helmet purchase programs resulting in the purchase of 1,182 helmets. Low-income families received 4,695 safety seats through 97 community programs and held numerous traffic safety presentations and safety seat workshops. Staff made 158 safety seat educational presentations to 12,369 individuals, conducted four National Highway Traffic Safety Administration's training classes for child passenger safety technicians, distributed 590,877 educational materials, responded to 6,213 technical phone calls on the use of safety seats, wrote and distributed four news releases, and developed a new PSA on child safety seats. (The motor vehicle death rate for children under 15 years of age in 1997 was 5.9 per 100,000 population, a slight decrease from the 1996 rate.)

In addition, TDH staff monitored hospitalization patterns of injured in Texas hospitals, established Safe Kids Coalition in Rio Grande Valley, and established "Take Time for Kids" link with Injury Program's web site.

TDH continues working to reduce the incidence of blood lead levels and to improve the follow-up process for children with elevated lead levels through its regional lead poisoning prevention teams at each TDH public health region. In 1997, 267,049 screens were completed, out of which 1,597 received follow-up services in all 18 identified zip-coded areas with high lead levels. Staff delivered 20 presentations and sent 1,597 notification letters to parents of lead-poisoned children, and approximately 1,437 notification letters were sent to health care providers.

III. REQUIREMENTS FOR APPLICATION

3.1 Annual Budget and Budget Justification

3.1.1 Completion of Budget Forms

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

3.1.2 Other Requirements

Maintenance of Effort

Texas will continue to provide the maintenance of effort amount of \$40,208,728.

Special Projects

Texas is funding several special projects using Title V and related general revenue funds including: University of Texas Callier Center (hearing screening); University of Texas Southwestern Medical Center (advanced nurse practitioner training); Texas

Agricultural Extension Agency (parenting); University of Texas Medical Branch at Galveston (Healthy Families); Parkland Hospital (North Texas SIDS counseling and prevention); University of North Texas (teratogen hotline); City of Laredo Health

Department (neural tube); (Children's Health Insurance Pilot Project); Hearing Health Institute (newborn hearing screening) UT, Austin; UTMB, Galveston; Texas Tech; UT, Dallas; and Texas School for Deaf (hearing screening).

Other Sources of Funding

Texas also receives a variety of other federal, state, and private grants: 1) MCHB (State Systems Development Initiative); 2) Centers for Disease Control and Prevention (prevention of recurrence of neural tube defects); 3) MCHB (Texas Genetics Network); MCHB (newborn screening sickle cell program); 4) CDC (early detection of breast and cervical cancer); 5) MCHB (Healthy Child Care North Texas); 6) Texas Cancer Council (regional school health specialists); 7) Centers for Disease Control and Prevention (prevention of secondary disabilities); and 8) Childhood Immunization (Integrated Public Health Information System).

Significant Year to Year Budget Variations

The Texas Legislature allocates Federal Title V block grant funding and state general revenue funding to two strategies within the Texas Department of Health: 1) Maternal and Child Health (MCH) and 2) Chronically Ill and Disabled Children's Program (CIDC). The state general revenue dollars for these two strategies include both the matching dollars and the overmatch. The overmatch of general revenue dollars is allocated to the CIDC strategy.

In the past, TDH has transferred state general revenue dollars from other strategies to the MCH and CIDC strategies to compensate for the highly fluctuating spending patterns in the CIDC strategy. Recently, dollars have been transferred from the CIDC strategy to the MCH strategy as expenditures in the CIDC strategy had declined due to policy and other funding changes that took place in the mid-90s. The most significant of these changes was a policy that required potentially eligible CIDC clients to first apply for Medicaid, and the implementation of OBRA89, which resulted in Medicaid reimbursement for a variety of services that CIDC had been covering. Because of the changes, TDH was able to transfer some of the unexpended CIDC dollars to the MCH strategy and use these funds for the provision of additional services for women and children. Over a number of years, TDH's expenditures for MCH services grew to approximately \$20 million over the state and federal appropriated amount for the MCH strategy. In 1996, budget cuts reduced this overspend to \$10 million.

Rider 4 of the 76th Texas Legislature does not permit any further transfers from CIDC to MCH. In addition, legislation was enacted in the last legislative session that calls for expansion of the CIDC Program. This legislation removes the diagnosis restriction for CIDC and allows all CSHCN to be served by the program regardless of diagnosis. It is expected that this policy change will result in all the funds being expended in the CIDC strategy. The result of both Rider 4 and the CSHCN legislation is that no additional dollars above the appropriated amount will be available for MCH strategy.

As TDH goes in to FY 2000, the Title V program has about \$23 million in federal carryforward. In addition, the MCH program is expending approximately \$10 million over appropriations. It is estimated that the Title V (MCH) program will spend down most of the federal carryforward over the next 2 years. The Texas Title V program intends to align the MCH budget with the federal allocation and the state general revenue appropriation by FY 2002. Preparations have begun to involve all stakeholders in a process that will address these policy and funding issues.

As a result, Form 2 indicates an increase in the carryforward from FY 1999 to FY 2000. This variation is largely due to the change in the amount of projected expenditures for FY 97. The improved methodology used to extrapolate the FY 97 expenditures shows a total of \$100,062,643, which is \$8,763,895 less than the amount reported in the FY 99 Block Grant Application. This variation contributed to the reported increase in carryforward for FY 2000.

3.2 Needs Assessment of the Maternal and Child Health Population

3.2.1 Needs Assessment Process

There were no significant changes in health problems, gaps, and health status in the MCH and CSHCN populations since the five-year assessment. The Associateship for Community Health and Resources Development is reviewing and updating the five-year assessment methodology and procedures to improve the identification and prioritization of the needs and resources of MCH and CSHCN populations. The review process consists of finding more efficient ways to: 1) collect, analyze, and report data trends in health status indicators and to target those that need attention to achieve the national and state performance measures; 2) update data comparisons by geographical areas and by ethnic groups; and 3) involve local communities in the process by developing a plan for more local input and consumer input, especially in the CSHCN program.

3.2.2 Needs Assessment Content

3.2.2.1 Overview of the Maternal and Child Health Population Status

No significant changes.

3.2.2.2 Direct Health Care Services

No changes.

3.2.2.3 Enabling Services

No changes.

3.2.2.4 Population-Based Services

No changes.

3.2.2.5 Infrastructure Building Services

No changes.

3.2.3 Priority Needs

The following is a list of MCH/CSHCN top priorities (Form 14) accompanied by a brief discussion of each priority/category of service:

a. Direct Services

Referrals for genetic screening services can be used to identify serious disorders which have long-term consequences for women, infants and children. FY 97 TDH monitoring of billing for genetics services showed a low utilization rate (22.4 per 10,000) of genetic services by women and children with lower rates in TDH public health regions 1, 4, 10, and 11. Medical and dental providers, school nurses, child care providers, and Early Childhood Intervention programs located in these four regions were surveyed to identify the reasons for the shortage of referrals for genetic services. Results indicated that the majority of providers did not know services were available. Similar results were obtained when surveying consumers about their knowledge of the availability of genetic services. Therefore, TDH Genetic Screening Division staff efforts will be geared toward the development and statewide implementation of effective genetic education programs for both providers of health and education services in order to achieve the target rate utilization of 31 per 10,000 women and children .

Texas Title V program pays for well and sick child care visits. The monitoring of FY 97 billing records of Title V contractors concluded that the percent of visits for sick care (58%) is higher than those for well child care (42%). If this trend continues, the lack of preventive care could negatively impact the immunization rates of children as well as the timeliness of treatment for conditions normally identified through well-child care. Consequently, Child Health and Safety Division staff put in place a new requirement in the FY 98 Title V policy manual for Title V contractors serving children to maintain a level of at least 50% well child checkups. The FY 98 billing records showed an increase in the percent of well child to 44%. For FY 2000, Title V Child Health and Safety Division staff will continue to increase well child care visits by promoting and educating parents and school-based clinics about the importance and benefits of preventive checkups.

b. Population-based Services

Lead poisoning is the most preventable of environmental diseases. Out of 142,547 children, a total of 6,472 up to six years old tested positive for lead poisoning (a rate of 45 per 1,000 showing elevated lead levels). In order to reduce the rate of children with elevated blood lead levels, Title V Children Health and Safety Division will continue to increase efforts to 1) ensure better access to needed services for

children with elevated lead levels, 2) train TDH regional lead poisoning prevention teams on identifying types and levels of interventions for children with elevated lead levels, and 3) notify Title V and Medicaid providers located in areas with high lead incidence.

In late summer 1992, TDH responded to an epidemic of cases of NTD-affected babies in the 14 counties along the Texas-Mexico border by securing a CDC grant and Title V funding. Our goals are to identify NTD-affected pregnancies in residents of the area, to provide education and folic acid supplementation to high-risk women of childbearing age, and to conduct research to identify factors contributing to newborns with anencephaly and spina bifida. Between 1993 and 1997, 301 women NTD-affected babies were born along the border, representing a rate of 13.4 per 10,000 live births.

Also, the 1997 Texas Women's Health Survey looked at women's awareness of folic acid and the prevention of NTDs. The following are the findings: 66 percent of Texas women said they had heard about folic acid, but less than 15 percent knew that they should take it before pregnancy, and only 16 percent knew that folic acid can prevent birth defects. Only 33 percent said they took daily supplements containing folic acid. Daily use of folic acid was lowest in the Lower Rio Grand Valley, the location of a 1991-1992 neural tube defect cluster that received national attention.

On average, more than 340 babies are born with neural tube defects in Texas every year. For FY 2000, efforts will continue to enroll high-risk women in folic acid intervention along the border and provide statewide education on the benefits of folic acid supplementation.

c. Infrastructure Building Services

Dental caries is perhaps the most prevalent disease known. The importance of optimal oral health for children cannot be overemphasized. Early diagnosis and prompt treatment of caries can stop tooth destruction and prevent tooth loss. Based on the 1997-98 TDH Statewide School Dental Survey of the School Lunch population, 3,407 third to seventh graders of 7,276 (47%) surveyed had caries. Title V Oral Health Program staff are committed to reducing this percentage by first determining baseline children's dental health status, which helps not only in assessing the unmet needs, but also in designing appropriate future activities addressing specific dental needs.

One of the TDH Women's Health Division priorities has been to decrease the prevalence of relationship violence through early detection and referral, which may prevent future injuries and decrease medical costs and lost days of work. Results of a five-year Title X Service Enhancement Project on family violence in Region VI (Texas, Arkansas, Oklahoma, Louisiana, and New Mexico) indicate that Texas women receiving services from four TDH family planning contractors said they had

experienced some form of sexual assault (27.3%) and physical abuse (38%) (Appendix J). Division staff conducted a series of activities for Title X family providers to prevent abuse and identify victims. In FY 2000, in addition to expanding these activities to Title V and other health care providers, Division staff will develop a monitoring system to identify suspected victims of relationship abuse across Texas.

Childhood obesity is associated with adverse medical and psycho-social consequences. Overweight acquired during childhood or adolescence may persist into adulthood with increased risks of some chronic disease later in life. As a result, the rising prevalence of obesity and chronic disease will place more burdens on the health care system, including increased costs of medical care.

Following published data from the CDC's Third National Health and Nutrition Examination Survey (NHANES III), concern has been expressed that the prevalence of obesity in children and adolescents may be increasing in Texas, but definitive data are lacking. NHANES III indicates that the prevalence of overweight from 1976-80 to 1988-94 had increased from 7.6% to 13.7% among children aged 6-11 years and from 5.7% to 11.5% in adolescents aged 12-17 years. In the 6-11 year old groups, obesity is highest in Mexican American boys and black girls. In adolescents aged 12-17 years, obesity is highest in black and Mexican American females. ages 6-15. Therefore, Title V leadership is committed to establishing a baseline to assess the extent of obesity in childhood in Texas and, accordingly, develop a plan of action to address this health risk.

3.3 Performance Measures

3.3.1 National "Core" Five Year Performance Measures

3.3.1. Five Year Performance Targets

See Supporting Documents, Form 11.

3.3.2 State "Negotiated" Five Year Performance Measures

3.3.2.1 Development of State Performance Measures

FIGURE 1
PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DH C	E S	PB S	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DH C	E S	PB S	IB	C	P	RF
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DH C	E S	PB S	IB	C	P	RF
1) The rate (per 10,000) of genetic services utilization among women and children in Texas.	X						X
2) The percent of well child visits of the total children's visits provided by Title V funded contractors.	X					X	
3) The rate (per 1,000) of elevated blood lead levels among Medicaid-eligible children up to age 6.			X				X
5) Incidence of carious lesions among 3rd - 7th grade children.				X	X		
8) Percent of female clients suspected of being victims of relationship violence.				X	X		
9) The rate (per 10,000 live births) of neural tube defects-affected babies.			X		X		
10) The prevalence of childhood obesity				X		X	

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

3.3.2.2 Discussion of State Performance Measures

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

a. Direct Services

An increase in referrals for genetic services may result in early detection of a disorder, as well as early intervention, providing families an opportunity to cope with genetic anomalies better and reducing treatment costs. These direct medical referrals, performed on a one-on-one basis, allow immediate initiation of treatments to ameliorate the consequences of the disorders through counseling and specialized care. In order to increase referrals for genetic services in FY 2000, TDH Genetic Screening Division staff are proposing a set of activities that consist of developing an effective educational program for both Title V providers and school personnel. The expectations from implementation of this educational program in schools are to dramatically increase the utilization of genetic services by school-age children, since: 1) many conditions do not manifest themselves until childhood; 2) mild mental retardation is often not recognized until a child has difficulty at school; 3) a number of children are known to have developmental delays but are not evaluated as infants because they may grow out of it; and 4) school personnel do not always recognize the need for genetic services for many children who could benefit from them. The increased utilization of genetic services leading to early detection and treatment of disorders could reduce the infant mortality and child death rates (which are already below the HP 2000 Objectives).

The importance of preventive health care services for children cannot be

overemphasized. In order to maintain at least a 50% well child to sick care visit ratio, staff from the Child Health and Safety Division are making varied efforts to: 1) promote the importance of preventive well checkups within communities; 2) encourage providers to use well-child guidelines ; and 3) serve as a resource for school nurses and school-based clinics through TDH regional school health education specialists. Focus on preventive care directly impacts childhood immunization rates as well as early diagnosis and treatment of medical conditions, and therefore reduces the death rate for children.

b. Population-based Services

Exposure to high levels of lead is toxic to the central nervous system and can be fatal. Even low levels of exposure, especially in children, can cause a variety of medical problems such as delayed learning and growth deficits. To reduce the prevalence of blood lead levels and the need for improving the follow-up process of children with elevated lead levels, TDH regional lead poisoning prevention teams in each public health region will receive extensive training on how to identify the type and level of interventions needed for children with elevated lead levels. The teams will also conduct additional population-based activities, such as maintaining contact with providers and parents, assisting with follow-ups, and serving as a resource for education on lead poisoning prevention. The achievement of this performance measure will positively impact infant mortality and child death rates.

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

c. Infrastructure Building Services

It is imperative for the Title V Oral Health Program to determine baseline children's dental health status and to survey existing knowledge and behavior on the usage and benefits of oral health practices. The achievement of these infrastructure-building activities will allow dental program staff to set realistic targets and develop targeted prevention activities in order to reduce the prevalence of dental caries. According to scientific publications, dental caries can sometimes be linked with child deaths.

Relationship violence often results in emergency room visits, physician office visits, hospitalizations, lost days of work, mental or emotional problems, or death. Studies show that more than half of the women murdered in the United States are killed by their male partners. It is estimated that, nationally, domestic violence leads to \$44 million in total annual medical

costs and 175,000 lost days of work. Texas contributes to these alarming statistics as indicated by the results of the five-year Title X Service Enhancement Project (Appendix J). Consequently, TDH Women's Health Division staff have conducted a series of activities for Title X family planning providers to prevent abuse and identify victims for referral. In FY 2000, similar infrastructure-building activities, such as the development of a tracking system for suspected victims of abuse and the provision of abuse prevention training, will be expanded to Title V and other interested health care providers. Reduction of relationship violence to women (including women before and during pregnancy) and their children would have an impact on outcome measures 1, 3, 4, 5, and 6, relating to the mortality rate for children from the perinatal period through the early childhood period.

Based on national data on childhood and adolescent obesity, action must be taken now to prevent a potential epidemic of childhood obesity in Texas. Priority attention by Texas Title V leadership is needed to determine a baseline for the prevalence of childhood obesity among a randomized state sample of 4th, 8th, and 11th grade students and to collect data on menu planning procedures, preparation of foods, and nutrition-related policies from participating schools. Once the baseline is determined, the Title V Child Health and Safety staff, along with the Division of Nutrition Services staff, will assess the unmet needs and develop strategies for achieving the HP 2000 objective for adolescents. Childhood obesity is associated with numerous medical and psycho-social problems which can negatively impact the mortality rate for children.

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

The following is a brief explanation of the deletion of three of the state performance measures that no longer appear in the FY 2000 Annual Plan.

1. Percent of school-age children receiving oral health education. In the FY 1999 Annual Plan, two state performance measures which relate to oral health were included. The first one related to the importance of oral health education among school-age children, and the second referred to decreasing the prevalence of carious lesions among the same population. Oral Health Division staff decided that there was no need to have two performance measures which were aimed at fulfilling the same purpose of reducing the presence of caries in children. Since oral health education is the foundation for preventing dental disease, they eliminated the oral health

education measure but incorporated its activities under the current dental health state performance measure on the prevalence of carious lesions. The completion of the proposed activities will establish baselines for students' knowledge and behavior concerning the benefits of good oral health practices. This baseline data will present an opportunity to design appropriate educational oral health strategies which, in turn, will impact the prevalence of carious lesions. This change is supported by comments received in the FY 99 Title V public input.

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

The delivery of quality health care for CSHCN has been a top priority of program staff, as is suggested by the appearance of this state performance in the FY 98 Annual Plan. In FY 99, MCHB finalized a set of national performance measures that included a performance measure on the percent of CSHCN who have medical/health home. This national performance measure is similar to the state performance insofar as the adequacy of the medical/health home depends on (among other factors) access to and the quality of services delivered to CSHCN and their families. CSHCN program staff eliminated the state performance measure but proposed its activities under the medical/health home measure. The proposed activities for FY 2000 are to develop an operational definition for assessing the unmet needs and to establish parameters defining high quality of care for CSHCN and their families. Several comments were made during the FY 99 Title V public input which support this revision.

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

This measure has been put aside, not because of its lack of importance, but due to the shortage of Public Health Nutrition and Training Division staff to undertake more projects. This measure remains one of the program's top priorities to TDH health nutrition staff who recognize the need for specialty training for licensed and registered dietitians so that appropriate nutritional care for complex pediatric problems will be provided. The development of a training curriculum on nutrition care of premature and/or low birth weight infants and its statewide implementation are planned for the near future.

3.3.2.3 Five Year Performance Targets

See Supporting Documents, Form 11.

3.3.2.4 Review of State Performance Measures

Not Applicable.

3.3.3 Outcome Measures

See Supporting Documents, Form 12.

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

4.1.1 National Performance Measures

Direct Health Services:

<p>01 Type: Capacity Population: CSHCN</p>	<p>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.</p>
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Action Plan

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

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

Monitoring: review of data on periodic basis.

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

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

Output Measure: number of SSI beneficiaries under 16 referred.

Monitoring: review of data on periodic basis, follow progress on referrals.

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

<p>02 Type: Capacity Population: CSHCN</p>	<p>The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.</p>
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Action Plan

1. Activity: Conduct surveys and/or workshops with community groups, consumers, and providers to gather information for the CSHCN redevelopment project.

Output Measure: number of surveys developed and/or number of workshops conducted.
Monitoring: document progress in scheduling and conducting surveys and/or workshops.
Evaluation: review workshop participant evaluation forms to determine the usefulness of the collected information, and assess the extent to which community input is considered and integrated into program development decisions.

2. Activity: Based on the information collected in Activity 1, review the comprehensive scope of service needs identified for CSHCN program and document the specialty and subspecialty services and the associated providers not currently funded by the state CSHCN services program.

Output Measure: list of services and providers not currently funded.
Monitoring: document progress toward generating the list.
Evaluation: review list of services and providers to ensure it is accurate, complete, and comprehensive.

3. Activity: Develop action plan and funding strategies to implement desired enhancements to service provision and provider base.

Output Measure: action plan and funding strategies developed.
Monitoring: follow progress in developing the different phases of the action plan and funding strategies, meetings' minutes.
Evaluation: assess the effectiveness of the processes used to develop the action plan and funding strategies.

4. Activity: Broad-based dissemination (both internal and external to TDH) of program information and policies regarding CSHCN services and providers.

Output measure: a standardized, coordinated procedure developed and implemented for disseminating program information, with special focus on policy changes.
Monitoring: track the procedure development and the process of implementing the procedure relative to program policy changes.
Evaluation: seek feedback from consumers, providers, agency staff (central office and regional) and others regarding the efficiency and effectiveness of the dissemination procedure and the understanding of program information/policies.

5. Activity: Evaluate current and future information and referral resources/needs as part of the Title V CSHCN program redevelopment and develop an MOU between CSHCN program and Texas Information and Referral Network.

Output measure: resources and needs identified, MOU developed.

Monitoring: follow progress toward the identification of resources/needs and the development of MOU.

Evaluation: assess improvements in providing adequate and appropriate information on CSHCN services through the Texas Information and Referral Network.

Enabling Services:

03

Type: Capacity

Population: CSHCN

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

Action Plan

1. Activity: Participate in developing and piloting an operational definition for CSHCN for managed care and other insurance such as CHIP pursuant to the 76th Texas Legislature Senate Bill 1165 in order to determine baseline data for CSHCN and assess the adequacy of health care for CSHCN.

Output Measure: operational definition developed, pilot has started.

Monitoring: keep minutes on the planning sessions and collaborative meetings with other participating agencies.

Evaluation: send out the definition for review, participate in the analysis of preliminary information and data obtained from piloting the CSHCN definition, when available.

2. Activity: Participate in defining high quality of care parameters for CSHCN, including a definition of adequate medical home, and develop a tool for data collection to measure the quality of care for CSHCN.

Output Measure: parameters defined; adequate medical home defined; tool for data collection developed.

Monitoring: track progress toward defining the parameters and developing the tool.

Evaluation: send out the parameters, definition, and tool for review and make needed changes.

Population-based Services:

04

Type: Risk Factor

Population: Women & Infants

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

Action Plan

1. Activity: Develop and implement a new methodology to establish baseline data for the number of newborns with at least one newborn screen.

Output Measure: methodology developed, baseline established.

Monitoring : review periodic updates concerning development and implementation of the new methodology.

Evaluation: analyze newborn screening data to determine the accuracy of the new methodology.

2. Activity: Continue implementing the revised “new” methodology and determine geographic areas with the highest number of missed cases of newborn screening.

Output Measure: number of geographic areas at risk that are identified.

Monitoring: review periodic updates concerning data collection.

Evaluation: analyze newborn screening data to validate methodology and geographic areas identified.

05

Type: Risk Factor

Population: Children

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

Action Plan

1. Activity: Continue statewide promotion and distribution of “My Child’s Health Record” to all parents regardless of income.

Output Measure: number of “My Child’s Health Records” ordered by hospitals, Title V providers, and other interested organizations.

Monitoring: check the status of the number of records ordered and distributed.

Evaluation: assess usefulness of “My Child’s Health Record” by conducting a survey of parents regarding their use of “My Child’s Health Record.”

2. Activity: Take Time for Kids Initiative develop and distribute a parent education magazine for children birth to 3 years of age. [The current TX Tots magazine (to be renamed “Take Time for Kids”) will be redesigned to give updated information relating to medical check-ups and immunizations for distribution to parents whose children are enrolled in Texas Health Steps (EPSDT)]

Output Measure: number of Take Time For Kids magazine distributed.

Monitoring: follow progress of magazine distribution.

Evaluation: assess the usefulness of Take Time for Kids magazine by enclosing in the mailout a brief questionnaire to be returned to TDH Bureau of Children’s Health.

3. Activity: Monitor Title V providers compliance with the TDH Immunization Division recommended immunization schedule.

Output Measure: number of quality assurance visits conducted.

Monitoring: review quality assurance site visit reports documenting compliance issues.

Evaluation: determine the number of providers in compliance with immunization policies.

4. Activity: In collaboration with Texas A&M Extension Service, Take Time for Kids initiative develop a training model to be used statewide by professionals, daycare staff and community leaders to increase parent’s knowledge and skills about importance of well-child check-ups, immunizations, and other children’s issues and conduct ten train-the-trainer workshops.

Output Measures: training model developed.

Monitoring: follow progress in developing the training model.

Evaluation: send out training model for peer review and make any necessary changes.

06

Type: Risk Factor

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

Population: Children

Action Plan

1. Activity: Continue providing family planning clinical and educational services to adolescents directly or through TDH contractors.

Output Measure: number of adolescents served by county/region.

Monitoring: review TDH contractor reports on the number and type of services delivered on a quarterly basis.

Evaluation: assess the overall change in the rate of birth for teenagers aged 15 through 17 years by county/region.

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

Output Measure: one statewide teen pregnancy fact sheet completed; 254 county teen pregnancy fact sheets completed; number of clinics and organizations receiving fact sheets.

Monitoring: ensure distribution of fact sheets.

Evaluation: assess the usefulness of the county fact sheet by enclosing a brief user questionnaire, to be returned to TDH, with the fact sheets when they are distributed.

3. Activity: Develop and distribute resource materials designed to raise public awareness of teen pregnancy in preparation for the Teen Pregnancy Prevention Month in May, 2000.

Output Measure: number and type of teen pregnancy prevention resource materials provided to communities in the state.

Monitoring: ensure distribution of resource packets.

Evaluation: assess the usefulness of the teen pregnancy prevention resource materials by enclosing a questionnaire, to be returned to TDH, with the materials.

07

Type: Risk Factor

Population: Children

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

Action Plan

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

Output Measure: number of material packets sent to parents, number of children participation in training curriculum.

Monitoring: ensure timely distribution of parent educational packets and Tattletooth curriculum to TDH regions and participating schools.

Evaluation: assess the usefulness of materials sent to parents by enclosing in the mail out a brief questionnaire to be returned to the Oral Health Division, conduct a pre- and post-test survey on 3rd graders who received the Tattletooth curriculum.

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

Output Measure: number of records in the statewide dental health status database.

Monitoring: follow progress of data entry, monitoring data quality control and make changes as needed.

Evaluation: Analyze data for accuracy and data integrity.

08

Type: Risk Factor

Population: Children

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

Action Plan

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

Output Measure: number of seats distributed by region.

Monitoring: follow development and progress of distribution system.

Evaluation: analyze data on the geographic distribution of safety seats and assess effectiveness of education by conducting a post-survey study on the proper use of safety seats.

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

Output Measure: number of helmets distributed by region.

Monitoring: follow development and progress of distribution system.

Evaluation: analyze data on the geographic distribution of helmets and assess effectiveness of education by conducting a post-survey study on the proper use of helmets.

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

Output Measure: number of presentations conducted by region, number of participating children.

Monitoring: follow progress in developing the curriculum and educational materials and document schedule of presentations.

Evaluation: conduct a pre- and post testing of children to ascertain transfer of traffic safety information.

4. Activity: Expand parenting education opportunities in communities through the community-based initiative, Take Time For Kids.

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

Monitoring: follow progress in conducting community workshops, document schedule of presentations and sign-in sheets.

Evaluation: review of workshop post-evaluation forms.

5. Activity: Integrate traffic safety information into Take Time for Kids parent education materials.

Output Measure: informational materials integrated.

Monitoring: ensure development and distribution of materials.

Evaluation: assess the effectiveness of materials by enclosing in the mailout a brief questionnaire to be returned to TDH Bureau of Children's Health.

6. Activity: Collaborate with the Texas Bicycle Coalition to provide bicycle safety training to children at regional Education Service Centers.

Output Measure: number of regional Education Services contacted.

Monitoring: document schedule of training.

Evaluation: assess willingness of Texas Bicycle Coalition to collaborate.

09

Type: Risk Factor

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

Population: Women & Infants

Action Plan

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

Output Measure: numbers of mothers who breastfeed their infants at hospital discharge and at six months.

Monitoring: review WIC data on a quarterly basis.

Evaluation: analyze data to identify the characteristics of breastfeeding mothers and nonbreastfeeding mothers at hospital discharge and at six months.

2. Activity: Continue to offer comprehensive breastfeeding promotion and management training to health care providers including Title V maternity and child health providers.

Output Measure: number of training sessions provided; number and type of

maternity and child health providers participating by county/region.

Monitoring: review of Clinical and Nutrition Training staff quarterly progress reports.

Evaluation: review training participants' evaluation forms, utilize pre- and post-testing of training participants to ascertain learning of breastfeeding information.

3. Activity: Maintain the current Texas Lactation Support Hotline capabilities.

Output Measure: number and type of calls received (i.e., information, referral, complaint) by county/region.

Monitoring: review hotline quarterly progress reports by the Texas Breastfeeding Initiative members.

Evaluation: conduct follow-up of calls to find out if concerns were addressed, accurate information provided, and appropriate referrals made. Develop and implement a system of "mystery callers" to determine hotline's effectiveness on a monthly basis.

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

Output Measure: number and type of educational materials developed; number and type of TTFK-affiliated groups who order breastfeeding materials.

Monitoring: survey TTFK-affiliated groups to ensure that materials were received.

Evaluation: develop and enclose a brief survey tool to be completed by TTFK-affiliated groups regarding the use and benefits of breastfeeding materials sent.

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

Output Measure: number of hospitals and birthing centers contacted, number of training sessions and technical assistance provided; number of hospitals and birthing centers accredited.

Monitoring: follow progress in providing training and technical assistance as requested; document training schedule and attendance.

Evaluation: survey all Texas hospitals that provide maternity services to determine the degree to which they are in compliance with the Baby Friendly Hospital Initiative.

6. Activity: Provide accessible breastfeeding training to private physicians and their staff.

Output Measure: number of physicians who received training by county/region.

Monitoring: follow progress in providing training and technical assistance as requested; document training schedule and attendance.

Evaluation: review training and post-test reports from the Professional Public

Health Education Division(CME/CNE Certification), randomly survey participating physicians to explore their perception of change in their behavior regarding breastfeeding support/counseling.

10

Type: Risk Factor

Population: Women & Infants

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

Action Plan

1. Activity: Update current standards and rules that are used for newborn hearing screening programs' certification.

Output Measure: number of standards and rules revised.

Monitoring: follow progress in revising standards and rules, document meeting minutes.

Evaluation: as appropriate, make necessary changes to standards and rules as a result of the monitoring and certification visits of newborn hearing screening programs.

2. Activity: Contact birthing hospitals by letter/newsletter to notify them of: 1) the mandate to screen newborns for hearing loss prior to hospital discharge, and 2) TDH roles and responsibilities in establishing certification criteria for implementing a newborn hearing screening program and in providing technical assistance, information management, reporting, and tracking system to programs.

Output Measure: number of birthing hospitals contacted.

Monitoring: document the number of staff at hospitals who attend pre-implementation training to set up their software and choose equipment.

Evaluation: assess effectiveness of process used to notify birthing hospitals.

3. Activity: Conduct newborn hearing screening implementation workshops for hospital staff about implementing newborn hearing screening programs

across the state, beginning with birthing hospitals with 1,000 or more births annually.

Output Measure: number of workshops conducted by region.

Monitoring: follow progress in number of hospitals participating and attendance level, track needed changes to be made in workshop as a result of the analysis of a participant satisfaction survey.

Evaluation: analyze participants' satisfaction surveys.

4. Activity: Train hospital staff in hearing screening protocols and use of patient management software.

Output measure: number of hospital staff trained.

Monitoring: document the schedule of workshops and attendance, track needed changes to be made in workshops as a result of the analysis of a participant satisfaction survey.

Evaluation: review participant satisfaction survey results.

5. Activity: Conduct monitoring and certification visits to newborn hearing screening programs at hospitals and birthing centers.

Output Measure: number of visits conducted by region.

Monitoring: document the schedule, location, and results of each site visit.

Evaluation: assess effectiveness of visits by polling hospital and birthing centers.

Infrastructure Building Services:

11

Type: Capacity

Population: CSHCN

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

Action Plan

1. Activity: Continue to refer CSHCN service program applicants who meet guidelines to Medicaid/ Medically Needy Program (MNP)

Output Measure: number of referrals made to Medicaid/ MNP.

Monitoring: track the status on each referral to Medicaid/MNP.

Evaluation: analyze data trends to assess the increase/decrease in the number of CSHCN applicants referred to Medicaid/ MNP who get Medicaid and/or MNP coverage as a result of referrals.

2. Activity: Participate in developing procedures to gather data on CSHCN who

apply for CHIP and/or Medicaid eligibility in order to assist them in obtaining or maintaining a source of insurance for primary and specialty care.

Output Measure: procedures developed.

Monitoring: track progress toward development of procedures.

Evaluation: assess to what extent procedures are compatible with other programs' (i.e., CHIP and Medicaid) eligibility and enrollment processes.

3. Activity: Develop rules and policies regarding the relationship of Title V CSHCN services to CHIP, Texas Healthy Kids, and Medicaid.

Output Measure: number and type of rules and policies developed.

Monitoring: follow progress in developing rules and policies.

Evaluation: assess to what extent rules and policies have been implemented.

12

Type: Process

Percent of children without health insurance.

Population: Children

Action Plan

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

Output Measure: percent of children without health insurance.

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

Evaluation: examine trends in child health insurance coverage and use data in program planning and interagency coordination efforts to increase the percentage of children with insurance coverage.

2. Activity: Confirm Title V program position through MOUs and procedures to integrate TDH Title V activities and data collection with CHIP and other state-funded insurance programs

Output Measure: MOUs and procedures developed, percentage of children without health insurance identified by Title V programs and referred to CHIP and other state-funded insurance programs.

Monitoring: track progress in development and implementation of MOUs and procedures, follow up on each referral.

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

13

Type: Process

Population: Children	Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.
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Action Plan

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

Output Measure: number of Medicaid children birth through age 20 who received a Medicaid service, number of children birth through age 20 who are potentially Medicaid eligible.

Monitoring: follow progress in updating report.

Evaluation: analyze trends of the number of potentially Medicaid eligible receiving a Medicaid paid service.

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

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

Output measure: number of contracts completed.

Monitoring: track progress on every step of the contracting process until completion (e.g., nomination process, list of potential applicants, interviews, etc.)

Evaluation: review the process and required criteria in selecting the best candidates.

2. Activity: Enhance TDH capacity to create family-centered program policies and services by developing a “family-centered practice” checklist to be considered for policy work and, as a local demonstration site for the National Center for Cultural Competence, by administering a cultural competency survey to consumers, providers, and administrators involved with the implementation of managed care programs.

Output Measure: number of parents of CSHCN participating in an advisory capacity, “family-centered practice” checklist developed, competency survey developed and administered, cultural competency plan developed (based on the survey results).

Monitoring: document attendance of family members in workgroups and task forces; review semi-annual reports, ensure distribution of cultural competency survey and follow progress in data collection and analysis.

Evaluation: assess to what extent parents were involved in the checklist and survey tool and plan were developed.

3. Activity: Identify ways to educate and train parents of CSHCN on the guidance instructions and requirements of the Title V Maternal Child Health Block Grant.

Output measure: action plan developed.

Monitoring: follow progress in developing action plan.

Evaluation: assess the pros and cons of each selected method and select the most appropriate method for parents of CSHCN to receive adequate training.

4. Activity: Evaluate the effectiveness of Title V information and referral system (e.g., BabyLove) on CSHCN population.

Output Measure(s): number of calls received regarding CSHCN issues.

Monitoring: keep track of the calls; follow progress in developing and implementing the caller satisfaction survey.

Evaluation: analyze data regarding calls to Title V I&R regarding CSHCN to determine the accuracy and appropriateness of the CSHCN information provided to callers.

15

Type: Risk Factor

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

Population: Women & Infants

Action Plan

1. Activity: Identify and rank geographic areas with high percentages of very low birth weight live births.

Output Measure: number of geographic locations identified with high incidence of VLBW births.

Monitoring: keep track of VLBW data reports by geographic areas and sub-populations at risk.

Evaluation: analyze and profile geographic areas with high incidence of VLBW births.

2. Activity: Assess the level and type of interventions needed for each geographic area and related sub-population at risk, and design effective strategies

to prevent the occurrence of very low birth weight live births.

Output Measure: report developed that includes a set of effective strategies and an implementation plan for each geographic area.

Monitoring: document minutes from meetings and/or conference calls with TDH regional staff and contractors located in selected geographic areas with high percentages of VLBW, review quarterly progress report on the pilot study.

Evaluation: analyze and profile geographic areas with high incidence of VLBW births before and after implementation of strategies.

16

Type: Risk Factor

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

Population: Children

Action Plan

1. Activity: Provide training and technical assistance on the use of the Mental Health C.P.R. video/curriculum to Regional School Health Specialists (SHS) and/or Safe and Drug Free School Specialists (SDFS).

Output Measure: number of participating SHS and SDFS by region, number of training sessions provided by region, number of times technical assistance was provided.

Monitoring: document the schedule of training and technical assistance sessions and attendance.

Evaluation: analyze participants evaluation forms and make necessary changes to the training curriculum.

2. Activity: In collaboration with Texas Education Agency, inform middle/junior and high schools, and programs serving teens to market the availability of the Mental Health C.P.R. video/curriculum through a loaner program in the 20 Education Service Centers.

Output Measure: number of schools by region receiving the videotape, number and type of programs by region receiving the videotape.

Monitoring: Follow progress in marketing the videotape and develop a system to track school and programs receiving the video/curriculum for follow up and monitoring purposes.

Evaluation: analyze geographic areas to assess areas of exposure to the video/curriculum, and to direct future marketing of the video/curriculum in areas with the least exposed; and to provide baseline for future impact analysis.

17

Type: Risk Factor

Population: Women & Infants

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

Action Plan

1. Activity: Present perinatal rules to the TDH Board of Health in July, 1999 to establish a statewide voluntary perinatal care system.

Output Measure: number of perinatal rules presented, number of rules approved.

Monitoring: keep track of the approved finalized rules and those needing revisions.

Evaluation: assess the Board's recommendations and revise as necessary.

2. Activity: Implement rules establishing a statewide voluntary perinatal care system and establish a reporting system for statewide oversight of the perinatal care system and cooperation.

Output Measure: number of Perinatal Resource Coordinating Groups (PRCGs) established in state.

Monitoring: keep track of the number and type of developments relating to the implementation of rules, review reports generated from the reporting and analysis system.

Evaluation: assess extent to which PRGCs and network structure are established; assess extent to which perinatal care improvement plans provide for comprehensive preconceptual, pregnant and postpartum care for women, their neonates, and their infants.

18

Type: Risk Factor

Population: Children

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

Action Plan

1. Activity: Identify and prioritize geographic areas with high percentages of infants born to women receiving late or no prenatal care.

Output Measure: number of geographic location identified with high occurrence of infants born to women receiving late or no prenatal care.

Monitoring: keep track of prenatal care beginning in the first trimester data reports by geographic areas and sup-populations at risk.

Evaluation: analyze and profile geographic areas with high occurrence of infants born to women receiving late or no prenatal care.

2. **Activity:** Assess the level and type of interventions needed for each geographic area and related sub-population at risk, and design effective strategies to increase the percent of infants born to women receiving prenatal care beginning in the first trimester.

Output Measure: report developed that includes a set of effective strategies and an implementation plan for each geographic area.

Monitoring: document minutes from meetings and/or conference calls with TDH regional staff and contractors located in selected geographic areas with high percentages of late or no prenatal care, review quarterly progress report on the pilot study.

Evaluation: analyze and profile geographic areas with high occurrence of infants born to women receiving late or no prenatal care before and after implementation of strategies.

4.1.2 **State Performance Measures**

Direct Health Services:

01

Type: Risk Factor

Population: All Title V Populations

The rate (per 10,000) of genetic services utilization among women and children in Texas.

Action Plan

1. **Activity:** Share the compiled list of effective genetic education programs with genetic providers and TEXGENE to select the most viable program for potential statewide implementation.

Output Measure: number and type of programs shared.

Monitoring: keep track of pros and cons of each program under consideration, and track requests for programs from providers.

Evaluation: assess educational program in selected by providers and monitor the rate of genetic services utilization in these areas.

2. Activity: Incorporate the selected educational program into the genetic state plan and develop a cost estimate for state plan implementation.

Output Measure: state plan that includes action plan with related outcomes and a cost estimate for implementation.

Monitoring: follow progress in developing the state plan.

Evaluation: send out the state plan for peer review and make necessary adjustments.

02

Type: Process

Population: Children

The percent of well child visits of the total children's visits provided by Title V funded contractors.

Action Plan

1. Activity: Take Time for Kids Initiative develop and distribute information package to parents about the importance of well child health care through community coalitions, Title V providers and conferences.

Output Measure: number of materials developed/revised and distributed to parents.

Monitoring: track the number and type of phone calls received through BabyLove Hotline requesting information.

Evaluation: assess the effectiveness of the information package by enclosing in the mailout a brief questionnaire to be returned to Take Time for Kids Initiative staff for analysis.

2. Activity: Encourage Title V and other providers' use of well-child guidelines such as American Academy of Pediatrics, Bright Futures, Pediatric Putting Prevention Into Practice (PPPIP), and Guidelines for Adolescent Preventive Services (GAPS).

Output Measure: number and type of providers contacted, number and type of providers who are using one or more of the well-child guidelines.

Monitoring: develop a system to track those contractors who are using at least one of the well-child guidelines.

Evaluation: assess the effectiveness of providers' use of guidelines by enclosing in the mailout a brief questionnaire to be returned to TDH Bureau of Children's Health for analysis.

3. Activity: Develop training and materials for school nurses to promote principles of core public health, including the importance of well-child check-ups.

Output Measure: number and type materials developed.

Monitoring: follow progress in developing educational materials, document the

schedule of workshops and attendance.

Evaluation: send out material for peer review and make any necessary changes.

4. Activity: Award grants to school-based health centers (SBHC) through a competitive request for proposals (RFP) designed to reduce student absenteeism, help them meet academic potential and stabilize the physical well-being of students.

Output Measure: RFP developed, number of SBHC fitting criteria funded.

Monitoring: follow progress in developing and disseminating the RFP, develop a system to track applicants, negotiations and funding decisions.

Evaluation: review quality site visits reports; monitor reduction in absenteeism.

Population-based Services:

03

Type: Risk Factor

Population: Children

The rate (per 1,000) of elevated blood lead levels among Medicaid-eligible children up to age 6.

Action Plan

1. Activity: Reduce the interval time between blood lead screening and diagnostic to appropriate level by notifying regional lead contacts, providers and parents of children with lead levels of 20 ug/dL and greater about potential lost-follow ups and needed referrals.

Output Measure: average time for notification for blood lead screen of 20 ug/dL or greater.

Monitoring: send returned letters to regional offices for follow-up.

Evaluation: conduct a random sample of children with elevated lead levels and monitor the time interval between the screening and notification.

2. Activity: Complete training of TDH regional lead poisoning prevention teams on the triage system designed to identify the type and level of interventions needed for children with elevated blood lead levels, and continue regular meetings of the TDH Lead Work Group, consisting of representatives from central office and regional programs involved with lead, to ensure the triage system is working and to address issues and concerns of the representatives.

Output Measure: number of regional training sessions provided, number of regional staff trained.

Monitoring: follow progress in scheduling and providing training sessions and Lead Work Group meetings.

Evaluation: review training participant evaluations and make necessary changes to the training format and/or content.

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

Output Measure: number of manuals sent.

Monitoring: ensure distribution of manuals and keep track of those providers in areas of high lead incidence.

Evaluation: assess the effectiveness of the manual in helping providers dealing with children with elevated blood lead levels by enclosing in the mailout a brief questionnaire to be returned to TDH Bureau of Children’s Health.

09

Type: Risk Factor

The rate (per 10,000 live births) of neural tube defects - affected babies

Population: Women.

Action Plan:

1. Activity: Continue identifying NTD-affected pregnancies among residents of the 14 Texas-Mexico border counties through NTD active surveillance.

Output Measure: number of women with NTD-affected pregnancies.

Monitoring: follow up on prospective case finding through the following data sources: hospitals, birthing centers, abortion centers, ultrasound centers, prenatal clinics, genetic clinics, and birth attendants such as lay midwives, certified nurse midwives and non-hospital physicians.

Evaluation: assess the effectiveness of the surveillance through the occurrence of undetected cases with NTD-affected pregnancies in the 14 border counties which resulted in NTD-affected babies.

2. Activity: Enroll high-risk women in folic acid intervention and provide education and folic acid supplementation to decrease the risk of NTD recurrence.

Output Measure: number of women participating in folic acid intervention program.

Monitoring: follow up on the status of enrollment in the folic acid intervention program.

Evaluation: study the factors that appear to influence enrollment.

3. Activity: Conduct case-control study on women who are identified through surveillance who reside in the 14-county study area at the time of delivery or termination of their NTD-affected pregnancy and who continue to reside in the area at the time of the case-control study.

Output Measure: number of eligible case-women who are participating; number of eligible control-women who are participating.

Monitoring: collaborate on a continuous basis with the labor and delivery units within the 21 hospitals along the border and follow-up on case or control deliveries.

Evaluation: conduct a risk analysis among case and control-women to delineate

risk factors for NTD-affected pregnancies along the border.

4. Activity: Distribute new/revised folic acid educational materials to TDH contractors, including WIC, Title V, Title X, and Title XX clinics.

Output Measure: number of TDH folic acid and women's nutrition brochures ordered from the TDH warehouse by region, number of new CDC folic acid brochures distributed to TDH contractors.

Monitoring: ensure distribution of brochures, review quarterly reports on usage rates of the brochures.

Evaluation: assess the usefulness of these brochures by enclosing in the mailout a brief questionnaire to be returned to the MCH Nutritionist Consultant.

5. Activity: The Division of Women's Nutrition in collaboration with the Division of Public Health Nutrition & Education distribute a new protocol on nutrition guidelines for women of childbearing age to TDH family planning contractors.

Output Measure: protocol developed.

Monitoring: maintain and monitor a log of the mailout of the protocols.

Evaluation: send protocol for peer review and make needed changes.

6. Activity: Publish news articles on the benefits of folic acid supplementation for women of childbearing age in existing MCH newsletters and publications to TDH contractors.

Output Measure: number of articles published and mailed to TDH contractors by region.

Monitoring: maintain and monitor a log of the numbers and types of newsletters distributed.

Evaluation: conduct a follow-up survey to TDH contractors to determine usefulness of the articles about folic acid supplementation.

Infrastructure Building Services:

05

Type: Capacity

Population: Children

Incidence of carious lesions among 3rd - 7th grade children.

Action Plan

1. Activity: Establish a workgroup to revise and improve survey tool/ methodology and pilot the revised survey tool for a longitudinal survey (survey is hands-on and entails actually looking in the child's mouth) of the oral health status of all Texas 3rd - 7th grade children.

Output Measure(s): workgroup established, survey tool and methodology revised, report that includes findings of the pilot.

Monitoring: meetings' minutes and activities of the workgroup, keep track of major steps in conducting the pilot survey.

Evaluation: compare revised survey and methodology with the Association of State and Territorial Dental Directors needs-assessment protocol, assess the usefulness and appropriateness of the information and data collected through the pilot to help establish a baseline for the incidence of carious lesions among 3rd - 7th grade children.

2. Activity: Develop and administer a needs-assessment questionnaire for 3rd grade students to survey existing knowledge and behavior on the usage and benefits of oral health practices.

Output Measure: survey tool developed (tool would include question as to whether or not child received education via the Tattletooth curriculum), number of participating 3rd grade students by regions.

Monitoring: ensure distribution of the needs assessment survey, track schools responding to the survey.

Evaluation: test the validity and reliability of the needs assessment survey tool, assess the usefulness and appropriateness of the information and data collected through the survey to establish the existing levels of knowledge and behavior toward the importance and benefits of oral health practices.

3. Activity: Develop and administer survey tool to assess the needs for educational materials and audiovisuals for educators in school districts statewide.

Output Measure(s): needs assessment tool developed, number of participating schools by region (including the percentage of schools with oral health curriculum program implemented).

Monitoring: ensure distribution of the survey tool, track school educators responding to the survey.

Evaluation: send materials for peer review and make needed changes, assess the usefulness of the materials by enclosing in the mailout a brief questionnaire to be returned to the Oral Health Division.

08

Type: Capacity

Population: Women and adolescents

Percent of female clients suspected of being victims of relationship violence.

Action Plan

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

Output measure: data collection system developed; number of providers trained.

Monitoring: identify providers for pilot phase. Pilot the system for 3 months and

make necessary changes; conduct database quality assurance activities.

Evaluation: assess the usefulness of the information and data collected through the tracking system in determining the number of victims and identifying urgent and recurrent needs of victims of abuse.

2. Activity: Distribute the model policy to Title V and other interested health care providers upon request (the model policy addresses the issue of mandatory reporting and recommends assessment, treatment and referral options) and seek feedback on the implementation of the model policy and procedure for victims of family violence/relationship abuse.

Output measure: number of providers receiving the model policy.

Monitoring: ensure distribution of the model policy manual and follow-up on updating the model policy.

Evaluation: assess the usefulness of the policy manual by enclosing in the mailout a brief questionnaire to be returned to TDH.

3. Activity: Provide abuse prevention training to Title V providers and other interested health care providers.

Output measure: number of training sessions provided by public health region.

Monitoring: follow progress in providing training sessions as scheduled; document agendas and sign-in sheets.

Evaluation: review training participants' evaluation forms.

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

Output measure: number of community/local awareness campaigns.

Monitoring: follow progress of training regional staff to train providers; document meetings (agendas, minutes, and outcomes).

Evaluation: Assess the effectiveness of the community awareness campaign.

10

Type: Process

Population: Children & Adolescents

The prevalence of childhood obesity.

Action Plan

1. Activity: The Public Health Nutrition Coordinator in the Division of Public Health Nutrition and Education and TDH regional nutritionists collaborate with the University of Texas School of Public Health to implement a school-based monitoring survey to measure heights/weights and knowledge on the importance of nutrition and physical activity in a randomized state sample of 4th, 8th, and 11th grade students.

Output Measure: number of participating schools by region, number of

participating students by grade and region.

Monitoring: the regional nutritionists work with school administrators to collect and forward data to UT School of Public Health faculty for analysis.

Evaluation: review the survey's results which include obesity prevalence rates by schools and information on students' knowledge, attitude and behavior toward nutrition and physical activity.

2. Activity: The Public Health Nutrition Coordinator in the Division of Public Health Nutrition and Education and TDH regional nutritionists collaborate with the University of Texas School of Public Health to collect data on menu planning procedures, preparation of foods, and nutrition-related policies from participating schools' food service staff, teachers, and administrators.

Output measure: number of participating schools by region.

Monitoring: the regional nutritionists work with school administrators to collect and forward data to UT School of Public Health faculty for analysis.

Evaluation: review the survey's results which include information on nutrition education requirements for the schools and types of curriculum and materials available.

3. Activity: TDH regional nutritionists meet with school staff to review the surveys' results and develop jointly an action plan addressing areas where the school can improve its food service, physical activity programs, and nutrition/health curricula.

Output Measure: number of schools contacted by region.

Monitoring: document meetings' minutes, follow up progress in developing action plans and seeking concurrence from the Public Health Nutrition Coordinator in the Central Office Division of Public Health Nutrition and Education.

Evaluation: assess the degree of acceptance and willingness of the school administration toward making necessary changes.

4. Activity: The MCH Nutrition Consultant in the Central Office Division of Public Health Nutrition & Education develops educational materials on child obesity prevention and disseminates materials to the Take Time for Kids-affiliated groups.

Output Measure: number and type of educational materials developed and mailed.

Monitoring: follow up progress in developing and distributing materials to target groups, review of quarterly progress reports.

Evaluation: assess the usefulness and benefits of educational materials by enclosing in the mailout a brief questionnaire to be returned to the MCH Nutrition Consultant.

5. Activity: The MCH Nutrition Consultant develops a training curriculum on child obesity and preventive activities, and regional nutritionists conduct workshops for teachers, nurses, coaches, and school administrators.

Output Measure: curriculum developed, number of workshops conducted by region.

Monitoring: follow progress in developing curriculum, document schedule of workshops and participants' sign-in sheets.

Evaluation: send curriculum for peer review and make needed changes, review workshop participants' evaluations, conduct follow-up survey to workshop participants to see whether they made any environmental or policy changes in schools in order to improve the nutrition and physical activity behavior in students.

Figure 2 shows a schematic approach that begins with the identification of priorities (through needs/resources assessment) and ends in improved outcome measures. Eight priorities are listed for which resource allocation is assigned and activity plans have been designed to achieve the desired performance targets set for each performance measure. In order to impact positively the listed outcomes, among others, Texas Title V program has budgeted the following amounts to meet the health and health-related needs of the Title V population for FY 00: direct services, \$ 80,923,016; enabling services, \$8,659,503; population-based services, \$18,305,296; and infrastructure building services, \$12,843,677.

Table 4 shows the distribution of both performance measure types by levels of service and MCH populations group. All MCH population groups are affected by at least one state performance measure. The resources and activity plans as measured by performance measures might impact a great number of Title V eligible clients. In FY 98, Title V programs served 124,692 pregnant women, 441,702 infants < 1 year of age, 459,961 children 1 to 22 years of age, and 26,848 children with special health care needs.

Figure 2

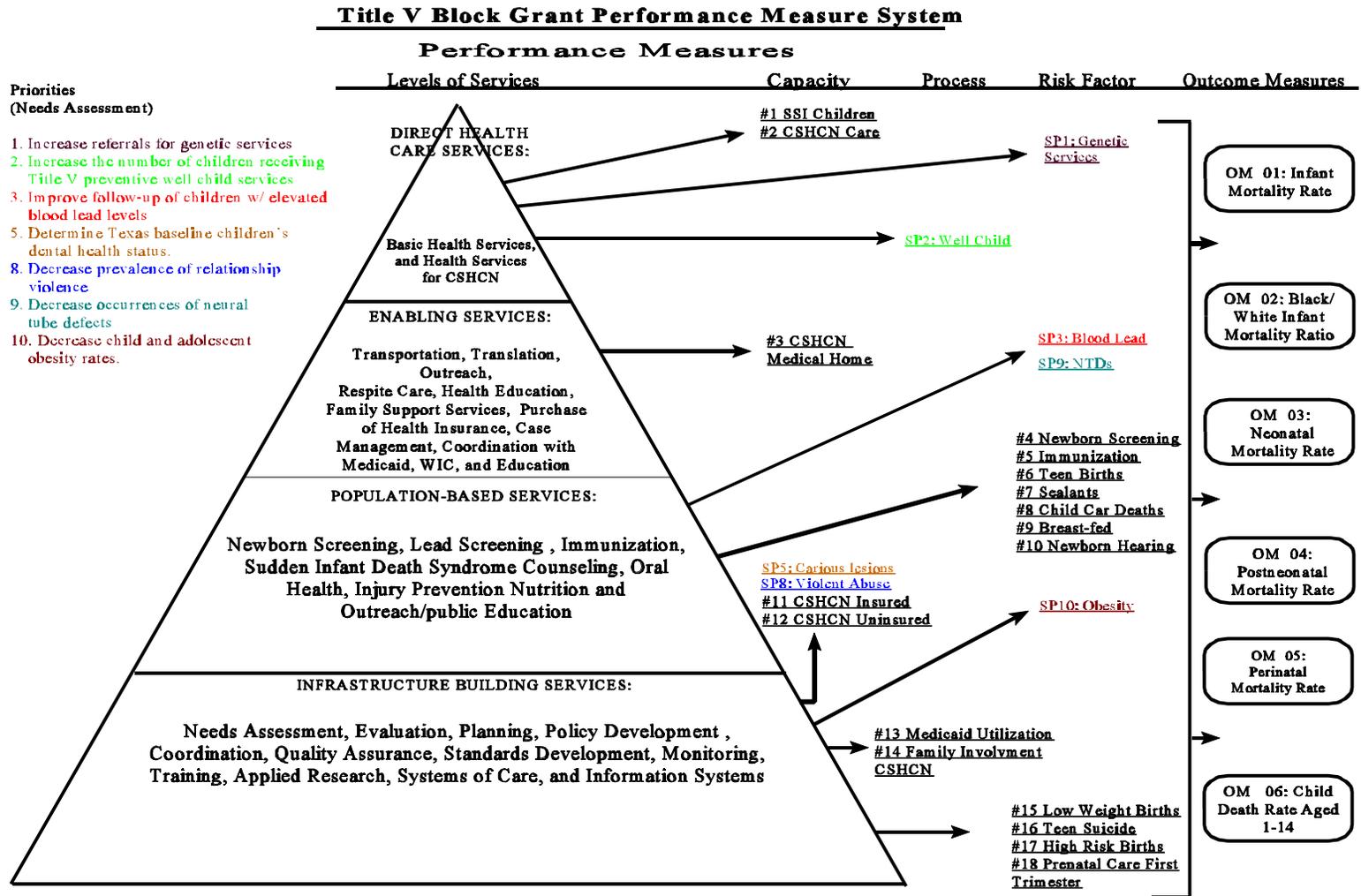


Table 4 **Distribution of National and State Performance Measures**

<div style="border: 1px solid black; padding: 5px; display: inline-block;"> ■ National Measure ■ State Measure </div>		by Levels of Service and MCH Population Groups			
		MCH POPULATION GROUP			
LEVEL OF SERVICE	Women	Infants < 1 Year Old	Children 1 to 22 Years Old	Children with Special Health Care Needs	
Direct Medical & Dental Care Services <u>Examples:</u> basic health services, and health services for CSHCN	<ul style="list-style-type: none"> • <i>genetic services</i> 	<ul style="list-style-type: none"> • <i>genetic services</i> 	<ul style="list-style-type: none"> • <i>genetic services</i> • <i>well child care</i> 	<ul style="list-style-type: none"> • SSI beneficiaries • specialty & sub-specialty services • <i>genetic services</i> 	
Enabling Services <u>Examples:</u> transportation, translation, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC, and education		<ul style="list-style-type: none"> • <i>blood lead levels (follow-up and notification letters)</i> 	<ul style="list-style-type: none"> • <i>blood lead levels (follow-up and notification letters)</i> 	<ul style="list-style-type: none"> • medical home 	
Population-based Services <u>Examples:</u> newborn screening, lead screening, immunization, sudden infant death syndrome counseling, oral health, injury prevention, and outreach/public education.	<ul style="list-style-type: none"> • breastfeeding • <i>neural tube defects</i> 	<ul style="list-style-type: none"> • genetic disorders • hearing impairment • <i>neural tube defects</i> 	<ul style="list-style-type: none"> • immunization • teen pregnancy • protective sealants • motor vehicle-related deaths • <i>blood lead levels</i> 	<ul style="list-style-type: none"> • <i>neural tube defects</i> 	
Infrastructure Building Services <u>Examples:</u> needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, and applied research	<ul style="list-style-type: none"> • <i>relationship violence</i> 	<ul style="list-style-type: none"> • VLBW live births • VLBW infants delivered at Level III facilities • infants born to women receiving prenatal care 	<ul style="list-style-type: none"> • children without insurance • Medicaid eligible children • deaths by suicide • <i>relationship violence</i> • <i>childhood obesity</i> • <i>students' dental health status</i> 	<ul style="list-style-type: none"> • source of insurance • family participation 	

4.2 Other Program Activities

Toll-free Hotline

“BabyLove” is the statewide toll-free line that provides information on programs in the Associateship for Community Health and Resources Development. In addition, this line provides information and referral (I&R) on public/private providers of health and human services that complement the health services provided by TDH. The target populations for the toll-free line include: children from birth to 21, CSHCN, women, parents, child care-givers, school health providers, family health-care providers, community leaders, and outreach workers.

Associateship for Community Health and Resources Development programs listing the BabyLove number include:

- Children’s Health and Safety (including the Take Time for Kids initiative)
- Texas Health Steps (formerly EPSDT)
- Children with Special Health Care Needs
- Medically Dependent Children Program
- Newborn Screening
- Program for Amplification for Children of Texas (PACT)
- Texas Genetics Network (TEXGENE)
- School Health
- Nutrition services for Women, Infants and Children (WIC)
- Family Planning
- Prenatal Care
- Oral Health Services
- Medical Transportation

Related services on which information is generated include:

- Medicaid
- Food Stamps
- Temporary Assistance for Needy Families (formerly AFDC)
- Early Childhood Intervention (ECI)
- Immunizations
- parenting classes
- service providers for the blind or visually impaired (Texas Commission for the Blind)
- service providers for substance abuse (Texas Commission on Alcohol and Drug Abuse)
- service providers for mental illness and mental retardation services (Texas Department of Mental Health and Mental Retardation)
- Texas Special Education hotline (includes information on children with disabilities, section 504 of the Rehabilitation Act)
- Texas Rehabilitation Commission (job training for persons with disabilities)
- Referral to licensed day-care services
- Information on resources for children who are medically fragile

During 1998-99, the Associateship convened an Information and Referral (I&R) Workgroup to examine the current and future needs of BabyLove. As a result, TDH updated the BabyLove data base, purchased new I&R software, obtained I&R Specialist training and certification for the BabyLove manager, and began a process of quality improvement around program data collection, monitoring, and evaluation.

Coordination with Medicaid

The Texas Health Steps (formerly EPSDT) program is operated by TDH and is administered through a division under the Bureau of Children's Health. All program activities are coordinated.

The Texas Department of Human Services (DHS) is responsible for Medicaid eligibility determination. TDH has an interagency contract with DHS to: a) perform oral information and referral on Texas Health Steps, Family Planning, and Immunization services to newly eligible and recertified Medicaid clients; and b) provide client eligibility data to TDH to facilitate program outreach and effective utilization of services. Under the contract TDH is responsible for providing educational materials including videotapes for DHS waiting areas. Both agencies agree to share information and collaborate on issues related to coordination of the TDH Texas Health Steps, Family Planning, Immunizations, Managed Care, and other Medicaid services. Each year, TDHS and TDH staff receive a copy of the MOU and review it for changes for the next year. At TDH, the Grants Monitoring Division coordinates final changes, if needed, in the MOU. The MOU is signed by each agency Commissioner and is published in the Texas Register. MOUs are equivalent to state rules.

TDH also has an MOU with the Texas Education Agency for the School Health and Related Services (SHARS) program. The SHARS program allows school districts to claim Medicaid reimbursement for ten health-related services (occupational, physical and speech therapy, medical, school health and psychological services, assessments, audiology, counseling, and special transportation). School districts certify the state share using existing state and local funds to receive the federal share. The MOU outlines individual agency and joint responsibilities for program administration including communication with school districts, data collection, training, development of state rules, rate setting, and claims payment.

CSHCN program staff provide leadership in Medicaid medical policy development, in particular that for CSHCN, and the Medicaid Waiver (Medically Dependent Children Program) is located in the CSHCN program.

Coordination with other Federal Programs

The Associateship for Community Health and Resources Development administers both the WIC and Women's Health Division Maternity and Family Planning Programs (Titles V, X, XIX, and XX). The Title V program coordinates regularly with these programs. TDH also serves as a member of the Texas Planning Council for Developmental Disabilities; the TDH representative to the Council is from the Bureau of Children's Health.

MOU for Coordinated Services to Children and Youth

TDH, DHS, the Texas Commission for the Blind and Visually Impaired, the Texas Department of Mental Health and Mental Retardation, the Texas Education Agency, the Texas Juvenile Probation Commission, the Texas Rehabilitation Commission, the Texas Youth Commission, the Department of Protective and Regulatory Services, the Texas Interagency Council on Early Childhood Intervention, and the Texas Commission on Alcohol and Drug Abuse maintain an MOU to coordinate services to children and youth whose need services from more than one agency. The MOU provides support for the state Community Resource Coordination Group (CRCG) Advisory Committee and 157 local CRCGs. CRCGs schedule staffing on individual children and develop strategies to address their multiple service needs through coordination of resources. TDH social workers are represented on all local CRCGs, and TDH central office staff serves on the State Advisory Committee. The state CRCG Advisory Committee meets regularly and reviews its MOU annually.

Providers Who Refer Pregnant Women and Infants to Title XIX

In FY 1999 TDH contracted with 86 providers across the state to provide MCH services including maternity, family planning and child health services. As part of the Title V eligibility determination process, Title V policy requires all providers to screen applicants for potential Medicaid eligibility. Potentially eligible Medicaid clients are referred to DHS. TDH has a software agreement with DHS to use the DHS Texas Eligibility Screening System (TESS) software to determine potential eligibility for services. All Title V providers are encouraged to use the TESS system, or to collect equivalent information using other screening tools approved by TDH.

Coordination with CSHCN-related Agencies and Family Leadership and Support Programs

As stated earlier (in Section 1.5.1.2, Program Capacity) TDH coordinates regularly with the Texas Rehabilitation Commission Disability Determination Unit concerning children who are SSI-eligible.

TDH continues to involve consumers and advocates in program design and implementation and in statewide policy development. TDH has a CSHCN Advisory Committee (CSHCNAC), established by the Texas Board of Health (BOH), whose purpose is to advise the BOH on issues affecting CSHCN. Twelve of the 18 members are parents of CSHCN, seven are both parents and service providers; and the remainder are service providers or interested persons. The CSHCNAC reviews and comments on policies, rules, and procedures and provides input to the MCH Block Grant.

Members of the advisory committee to the "On the Right Track" prevention grant include family members of CSHCN. The "On the Right Track" grant is a four-year grant awarded to TDH in July, 1997 by the Centers for Disease Control and Prevention for the purpose of preventing secondary conditions in the learning domain among people with disabilities.

In addition, families and advocates are active in state policy and systems

development as partners with personnel from TDH and other Texas human service agencies and organizations on the Regional Advisory Subcommittees for CSHCN in Medicaid Managed Care. Parents and interested consumer advocates have participated in monthly meetings to address policy and systems issues pertinent to CSHCN as Medicaid Managed Care is implemented in Texas. Several of the parent members of the CSHCNAC participate on the Houston CSHCN Regional Advisory Subcommittee.

Parents throughout the state advised the "Families are Valued" Project of the Texas Health and Human Services Commission (HHSC) on permanency planning sites and training. Parents continue to participate on the Interagency Workgroup for Children with Severe Disabilities where, along with agencies, advocates and organizations, major developments and activities relating to CSHCN are addressed. Parents participated in technical assistance groups for House Bill 406-the consolidation of Medicaid waivers, by reviewing quality assurance mechanisms and by participating on the steering committee with the Disability Policy Consortium, United Cerebral Palsy of Texas, and Advocacy, Inc. to produce the final report. Parents attended the National Conference on Disability and Health, Workgroup on 2010, to provide input and assist with prioritizing. Additionally, Title V CSHCN program staff are working with HHSC and the Texas Council on Developmental Disabilities to convene community meetings at the four "Families are Valued" Project sites (El Paso, Amarillo, Richmond, and Austin) in August 1999. At the meetings, community members will assess progress on their respective community plans (developed over a year ago) and consider issues and suggestions related to CSHCN program redevelopment needed to satisfy requirements from the 76th Texas Legislative session.

Parents of CSHCN gave input to enhance the Title V toll-free information service to accommodate and address the need for pertinent and accurate information for parents of CSHCN. Parents, as well as advocates and the CSHCNAC, will participate in the redevelopment plan for CIDC that will be necessary with the implementation of CHIP. CSHCNAC formed a workgroup to address this issue specifically.

4.3 Public Input

The Title V program solicited public input into the FY 2000 plan in 1999 by conducting a statewide mailing and by promoting feedback through the TDH web site MCH homepage. The mailing (Appendix K) was sent to approximately 1,434 interested persons, including consumers, TDH advisory committee members, professional associations, consumer advocacy groups, and Title V-funded service providers. In addition to the mailing, a public notice and copy of the packet was uploaded on the TDH Web Site, and an E-mail address was provided for email comments.

The public input packet included background information on federal block grant requirements concerning national and state performance measures, and solicited input about what to add, keep or change. The packet included two surveys: 1) National Performance Measures Survey; and 2) State Performance Measures Survey. The National Performance Measures Survey listed the national measures and current Texas activity plans and requested feedback about whether to "keep, revise or delete" activity plans implemented during FY 1999. It also requested alternative activity plans.

The State Performance Measures Survey listed the 1999 Texas state performance measures and activity plans. It requested feedback about whether to “keep, revise or delete” the proposed state performance measures and related activity plans as well as alternative measures and activity plans.

The final part of the packet was an open-ended section that encouraged respondents to suggest up to two new state performance measures and corresponding activity plans.

TDH received 82 sets of public comments from a variety of individuals and organizations. All comments were compiled and distributed to key program staff in the three bureaus. Staff reviewed the public comments to consider whether to keep, revise or delete the 1999 measures and activities plans, and whether to adopt alternative measures or activity plans. They reviewed the proposed new state performance measures and activity plans to consider new ideas for state priority needs and measures.

Comments were comprehensive and reflected diverse issues concerning Title V service delivery and its populations. Whenever possible, Title V staff translated comments and suggestions into performance measures and/or activities appearing in the proposed FY 2000 Annual Plan. Other suggestions are in need of further clarification and/or analysis and are currently on hold.

1. State performance measures. Most of the comments received were in support of the state performance measures and related activities. A great majority (68% to 87% of the total respondents) supported retaining state performance measures in their current forms or with revisions. Analysis of the comments led to the following changes. First, the elimination of the state performance measure, “percent of school-age children receiving oral health education,” and incorporation of its activities under the “prevalence of carious lesions in school-age children” state performance measure. Second, the merger of the state performance measure, “percent of children with special health care needs receiving high quality health care and health related services,” with the national performance measure on the percent of CSHCN who have medical/health home, as explained in Section “3.3.2.2. Discussion of State Performance Measures.” In addition, two new state performance measures were developed. The public input packet gave respondents the opportunity to suggest new state performance measures and corresponding activities. The feedback received from this section prompted the development of two new state performance measures concerning neural tube defect (NTD) and child obesity. Comments expressed overwhelming support for the need to educate women of childbearing age about taking supplemental folic acid in order to reduce cases of NTD-affected babies. They also suggested that Title V leadership should direct their efforts toward determining a baseline for child obesity in Texas school-aged children in order to assess the unmet needs and to prevent risks of some chronic disease later in life.

2. National Performance Measures. Comments received regarding activity plans under the national performance measures commended Title V services, while others called for improvements. In general, many respondents found that the information being disseminated through brochures, pamphlets, newsletters, and fact sheets to Title V interested individuals and organizations to be helpful. Others stressed the need for more collaboration with schools. In response, Title V Child Health and Safety Division staff included activities under state performance measure #2 which deal with the development of training and materials for school

nurses to promote principles of core public health and the availability of grants to school-based health centers. Other concerns were presented about the need to increase visibility of Title V services, to enhance the involvement of CSHCN program in managed care rollout, and to increase coordination with ECI program. All of these issues will be considered at the Title V stakeholders' meetings in Fall, 1999.

The FY 2000 Application also will be made available to facilitate comment after its transmittal. It will be uploaded into the MCH homepage on the TDH Web page. Copies will be sent to the Texas State Library, Governor's Office and the Legislative Budget Board and made available for TDH Advisory Committee members. A notice will be sent to all persons on the Title V interested persons mailing list to provide the opportunity to download or request a hard copy of the application.

4.4 Technical Assistance

See Supporting Documents, Form 15.

V. Supporting Documents

5.1 Glossary

GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [Title V Sec. 501(b)(3)]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year’s MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. [Title V Sec. 501(b)(4)]

Children - A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (For planning and systems development) Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. **State Program Collaboration with Other State Agencies and Private Organizations** States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection

and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists,

dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - *An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - *(see “Types of Services”)*

Measures - *(see “Performance Measures”)*

Needs Assessment - *A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:*

- 1) What is essential in terms of the provision of health services;*
- 2) What is available, and*
- 3) What is missing.*

Objectives - *The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)*

Other Federal Funds (Forms 2 and 3) - *Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.*

Others (as in Forms 4, 7, and 10) - *Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.*

Outcome Objectives - *Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.*

Outcome Measure - *The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”*

Performance Indicator - *The statistical or quantitative value that expresses the result of a performance objective.*

Performance Measure - *A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).*

Performance Measurement - *The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.*

Performance Objectives - *A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.*

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the Federal Title V Block Grant allocation, the Applicant's funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the State funds (the total matching funds for the Title V allocation - match and overmatch), Local funds (total of MCH dedicated funds from local jurisdictions within the State), Other Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and Program Income (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurances and Certifications**ASSURANCES -- NON-CONSTRUCTION PROGRAMS**

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

- 1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.*
- 2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.*
- 3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.*
- 4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.*
- 5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).*
- 6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.*
- 7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real*

property acquired for project purposes regardless of Federal participation in purchases.

8. *Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.*
9. *Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.*
10. *Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.*
11. *Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).*
12. *Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems*
13. *Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)*
14. *Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.*
15. *Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sects. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.*
16. *Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.*
17. *Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.*
18. *Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.*

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;*
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;*
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and*
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.*

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;*
- (b) Establishing an ongoing drug-free awareness program to inform employees about-*
 - (1) The dangers of drug abuse in the workplace;*
 - (2) The grantee's policy of maintaining a drug-free workplace,*
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and*
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;*
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;*
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-*
 - (1) Abide by the terms of the statement; and*
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;*

- (e) *Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;*
- (f) *Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-*
 - (1) *Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or*
 - (2) *Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;*
- (g) *Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).*

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

*Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201*

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) *No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.*
- (2) *If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)*

- (3) *The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.*

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. **CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. **CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

Figure 3

**CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES**

